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The Provision of Psychological Assessment Feedback to Children: A Survey of Practitioners

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The Provision of Psychological Assessment Feedback to Children:
A Survey of Practitioners

by

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DISSERTATION

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**THE PROVISION OF PSYCHOLOGICAL ASSESSMENT FEEDBACK
TO CHILDREN: A SURVEY OF PRACTITIONERS**

presented on April 18, 2019

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Table of Contents

Abstract	1
Introduction and Review of the Relevant Literature	3
Review of the Relevant Literature	6
Review of Psychological Assessment and Feedback	7
Collaborative and Therapeutic Assessment	10
Therapeutic Assessment	11
Assessment Feedback	12
Assessment Feedback in TA	17
Assessment Feedback with Children	17
The Utility of Assessment Feedback	20
Evidence for the Utility of Feedback with Children	25
Current Standards of Feedback Practice	28
Existing Literature on Feedback Practices	30
Rationale for the Present Study	33
Statement of the Problem	34
Purpose of the Study	34
Methods	36
Participants	36
Respondent Characteristics	37
Instrumentation	38
Data Collection	42
Procedures	43
Data Analysis	45
Results	45
Hypothesis Testing	45
Parties that Regularly Receive Test Results	45
Extent of Feedback Provision and Client Age	46
Extent of Feedback Provision and C/TA Practices	47
Research Questions	47
Frequency of Feedback Provision to Parents/Caregivers	47
Frequency of Feedback Provision to Children and Adolescents	48
Factors Associated with Feedback Provision	48
Feedback Provision and Graduation Year	48
Feedback Provision and Field of Degree	49
Feedback Provision and Practice Setting	49
Feedback Provision and Gender	49
Feedback Provision and Perspective on Ethical Responsibility	50
Feedback Provision and Perspective on Feedback Being Beneficial	50
Feedback Provision and Perspective on Feedback Causing Harm	50
Reasons for Providing Feedback	51
Barriers to Providing Feedback	51
Feedback Training	52
Feedback Provision and Sufficiency with Past Training	52

Open-Ended Survey Items	53
Factors to Increase the Practice of Feedback Provision	53
Purpose of Assessment and Feedback	55
Comments on Child-Directed Feedback	59
Discussion	63
Parties that Regularly Receive Test Results	63
Extent of Feedback Provision and Client Age	64
Extent of Feedback Provision and C/TA Practices	65
Factors Associated with Feedback Provision	66
Reasons for Providing Feedback	68
Barriers to Providing Feedback	69
Feedback Training	73
Feedback Provision and Sufficiency with Past Training	75
Limitations and Future Directions	76
Implications	78
References	81
Appendix A: Survey of Assessment Feedback Practices	105
Appendix B: Survey Recruitment Letter	112
Appendix C: Survey Recruitment Letter: Listserv	113
Appendix D: Informed Consent	114

List of Tables

Table 1. Demographics of Respondents	89
Table 2. Purpose of Child/Adolescent Assessment	90
Table 3. Parties that Regularly Receive Assessment Results	91
Table 4. Results of the Friedman Test for Differences Between Age Groups on Frequency of Feedback Provision	92
Table 5. Frequency of Feedback Provision to Parents/Caregivers	93
Table 6. Frequency of Feedback Provision to Children and Adolescents	94
Table 7. Results of Spearman's Correlation Between Frequency of Feedback Provision and Years Since Graduation	95
Table 8. Results of Spearman's Correlation Between Frequency of Feedback Provision and Perspective on Ethical Responsibility to Share Feedback	96
Table 9. Results of Spearman's Correlation Between Frequency of Feedback Provision and Perspective on Feedback Being Beneficial	97
Table 10. Results of Spearman's Correlation Between Frequency of Feedback Provision and Perspective on Feedback Causing Harm	98
Table 11. Reasons for Providing Feedback	99
Table 12. Barriers to Providing Feedback	100
Table 13. Sufficiency of Past Training in Providing Feedback to Children/Adolescents and to Adults	101
Table 14. Results of Spearman's Correlation Between Frequency of Feedback Provision to Children and Adolescents and Sufficiency of Past Training	102
Table 15. Helpfulness of Various Training Experiences in Learning to Provide Feedback to Children and Adolescents	103
Table 16. Level of Interest in Receiving Additional Training in Providing Feedback to Children and Adolescents	104

Abstract

Psychological assessment, long a cornerstone of psychological practice, has been the subject of substantial empirical research and clinical devotion. Far less attention, however, has been given to the process of assessment feedback—the task of communicating psychological test results to clients. Research has demonstrated the therapeutic value of providing clients with feedback, including improved insight and functioning. Providing assessment feedback is also mandated by professional standards. Still, to date, there is minimal published research examining the actual feedback practices of psychologists, or their perspectives on such practices. That which does exist focuses on adult testing clients, not children. It is largely unknown how the age of the individual assessed affects the feedback process.

This quantitative research was designed to address deficits in knowledge regarding the current feedback practices of psychologists who conduct assessments with children and adolescents, and to gather information on psychologists' perspectives regarding feedback, including reasons for giving or withholding feedback; their past training in the delivery of feedback; and how the process differs as a function of age. The study developed from an understanding that child-directed feedback is often overlooked and underutilized. Child-directed feedback is also under-researched, and thus a unique data collection instrument was developed. Descriptive and explorative analyses were utilized to test stated hypotheses and examine the research questions. Results suggested that most psychologists are regularly sharing results with parents/caregivers, but less so with assessed minors; this is despite much acknowledgment that feedback can benefit children. Analysis also found that inclusion in feedback differs by age, with younger children much less likely to receive results. Additionally, the frequency of feedback provision was associated with several factors, including psychologists' utilization of

collaborative and therapeutic assessment methods. Past training in feedback to children and adolescents was also examined, with only one-third of respondents strongly agreeing that their training was sufficient.

This study utilized a descriptive approach, but also aimed to further the discussion on child-directed feedback and ultimately motivate psychologists to make more informed decisions. It also demonstrates a commitment to working with children and adolescents in a helpful way. Implications and recommendations are further discussed.

Keywords: Feedback, assessment, children, survey, therapeutic assessment,
collaborative assessment

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The Provision of Psychological Assessment Feedback to Children: A Survey of Practitioners

Psychological assessment has been a cornerstone of clinical practice for close to a century, and it continues to be a defining feature of psychological expertise. According to Gerrig and Zimbardo (2002), psychological assessment can be defined as “the use of specified procedures to evaluate the abilities, behaviors, and personal qualities of people” (p. G-10). These “procedures” are uniform and standardized, and have long-assisted psychologists in case formulation, psychodiagnosis, and treatment planning (APA, 2010; Finn & Tonsager, 1997). Still, as aptly stated by Meyer et al. (2001), the “worth of the tool cannot be separated from the sophistication of the clinician who draws inferences from it and then communicates with patients and other professionals” (p. 153). It is the implementation of assessment activities, not simply the administration and scoring, that requires great skill and helps distinguish psychologists from psychiatrists, social workers and other mental health providers (APA, 2010; Meyer et al., 2001).

One such distinguishing skill is that of feedback provision—the task of communicating test results to clients and referral sources. Although feedback is now an ethical obligation (APA, 2010), it was historically considered harmful to the individual undergoing assessment and was rarely shared as part of an evaluation (Finn & Tonsager, 1997; Fischer, 1972; Tharinger, Finn, & Hersh et al., 2008). For years, the goal of assessment was to facilitate efficient communication between providers to make decisions about clients. Assessment was intended to serve an explanatory and information-gathering purpose, separate from but at times guiding therapeutic intervention (Ackerman, Hilsenroth, Baity, & Blagys, 2000; Finn & Tonsager, 1997). This view of assessment as distinct from intervention has, however, been met with increasing opposition over the past few decades. Some psychologists, notably those who practice collaborative and

therapeutic assessment, propose that assessment can be therapeutic in its own right (Finn, Fischer, & Handler, 2012; Finn & Tonsager, 1997; Meyer et al., 2001). Although the therapeutic effects described by clinicians and researchers are wide-ranging, the delivery of skilled, sensitive assessment feedback is consistently referenced as essential (Finn et al., 2012; Gorske, 2008; Poston & Hanson, 2010; Smith & Finn, 2014).

There is also accruing evidence in support of sharing personalized feedback. For example, Poston and Hanson (2010) conducted a meta-analysis to examine the therapeutic effectiveness of psychological assessment. The authors concluded that if testing is “accompanied by personalized, highly involving feedback, then clients and treatment appear to benefit greatly” (p. 210). Also, in a remarkable summary study of 126 meta-analyses and 800 large-scale studies on psychological test validity, the authors acknowledged that the “therapeutic impact” of assessment is strongest when “patients and relevant others are given detailed feedback about results” (Meyer et al., 2001, p.129).

In view of established ethical mandates (APA, 1992, 2002, 2010) and demonstrated empirical efficacy, one might assume that there is a consensus among psychologists regarding the practice of providing assessment feedback to clients. However, the literature suggests that feedback is frequently overlooked, both in practice and in research. Scholarship is especially sparse regarding the actual feedback practices of psychologists. That which has been conducted (i.e., Curry & Hanson, 2010; Peterson, 1998; Smith, Wiggins, & Gorske, 2007) suggests that most clinicians do not provide clients with feedback every time. Also, each of those published surveys focused on the provision of feedback to adults, not children (i.e., persons who are under the age of 18, regardless of state-based age-of-majority laws). According to Tharinger, Finn, & Wilkinson et al. (2008), there are yet few publications on child-focused feedback, “be they

conceptual, empirical, or pragmatic” (p. 611). This dearth in scholarship may be, at least in part, attributable to the fact that psychologists can meet the ethical standard to inform clients of test findings by sharing results with minors’ parents (APA, 2010; Tharinger & Pilgrim, 2012). Still, only a handful of guidelines have been published, to date, on how to broach feedback with children. There also appears to be a void in training when it comes to this area. That is, little attention has been devoted to guiding students and/or trainees on providing feedback to children (Curry & Hanson, 2010; Rupert, Kozlowski, Hoffman, Daniels, & Piette, 1999; Tharinger, Finn, & Wilkinson et al., 2008). Overall, it is largely unknown how psychologists manage child-directed feedback, or their perspectives on the practice. Such deficits in knowledge led to this survey research.

While there is a dearth in scholarship regarding the feedback practices of psychologists, a growing number of clinicians argue that to discount feedback, including with children, may be to miss a vital opportunity for therapeutic benefit. As implied above, the past few decades have seen some major shifts in the trends of psychological assessment. One broad shift that is particularly relevant to this research is that toward collaborative and therapeutic assessment practices. Unless otherwise differentiated, collaborative and therapeutic assessment will be jointly referred to as C/TA (as done so by Finn et al., 2012). Such approaches highlight the positive impact that can be made via psychological assessment. The assessors are committed to better understanding their clients and, with this knowledge, to directly intervening (Finn et al., 2012). A principal way in which C/TA assessors *intervene* is by actively engaging clients (of all ages) in the feedback process. As stated by Finn et al. (2012), “there is an emphasis on making this feedback useful, relevant, memorable, and enriching for clients, even if the client is a child” (p. 12). In the C/TA literature, it is argued that feedback, when provided to children in a way that

is understandable and sensitive to their developmental capacities, can elicit new understandings and enhance change in both the child and the embedded family system (Finn et al., 2012; Handler, 2012; Tharinger, Finn, & Hersh et al., 2008; Tharinger, Finn, & Wilkinson et al., 2008; Tharinger & Pilgrim, 2012).

Affiliates of C/TA appear particularly motivated to fill the gaps in knowledge regarding child-directed feedback, and some have begun to gather empirical data on specific feedback methods. Although research on these approaches is essential to better inform clinical practice, it seems also vital to collect information on the current feedback practices of psychologists who test children. That is, to acquire data on topics such as how frequently children are included in feedback sessions, whether inclusion differs as a function of age, and the reasons for and for not providing feedback to children and adolescents. This dissertation study sought to examine self-reported feedback practices, training, and perspectives, via Internet survey, from psychologists who conduct assessments with children and adolescents. To this end, it was designed to be descriptive in nature. At the same time, this research developed from an understanding that feedback, and particularly child-directed feedback, is underutilized and undervalued. The potential of gathering information to help move the field of assessment toward providing more comprehensive and thoughtful feedback to assessees of all ages thus underlay this research.

Review of the Relevant Literature

This section first offers a brief history of psychological assessment, including the temporal and academic environment that fostered and/or suppressed varied approaches. It then delves into specific approaches, with a focus on C/TA methods given their relative emphasis on the process of feedback. Next, literature on assessment feedback practices are explored,

including (a) a brief review of the history of feedback provision, (b) a description of client-directed feedback models, and (c) an examination of the research published on assessment feedback. Then, this section discusses the current standards of feedback practice in psychological assessment. Lastly, the purpose of the study is summarized, including the research hypotheses and questions that guided this empirical research.

Review of psychological assessment and feedback. Psychological assessment has been a core practice of psychologists for nearly 100 years. Prior to the Second World War, the principal and unique function of psychologists was psychological testing (Korchin & Schulberg, 1981). It was not until after World War II that those in the field of clinical psychology began to engage, alongside psychiatrists, in psychotherapy. Traditionally, the purpose of assessment was to clarify diagnoses and aid in decision-making about clients. Assessment was intended to provide valuable information to other professionals, in a reliable and resourceful way. According to Finn and Tonsager (1997), “by describing clients in terms of already existing categories and dimensions (e.g., schizophrenic, IQ of 100, 2g-7 code type on the MMPI-2), [information-gathering] assessors hope to convey a great deal of information about clients in an efficient manner (p.378).” Although referred to as the “information-gathering” model by Finn and Tonsager (1997), this approach to testing has also been termed the psychometric tradition. Korchin and Schulberg, for example, discuss the “psychometric tradition” as designed to gather objective and normative data in service of accurate psychiatric diagnoses and purposeful recommendations.

The assessment methods used to gather diagnostic information have long been varied and abundant, even dating back to the mid-20th century (Brown & McGuire, 1976; Louttit & Browne, 1947; Lubin, Larsen, & Matarazzo, 1984; Lubin, Wallis, & Paine, 1971; Sundberg,

1961). Not unlike today, instrument selection historically reflected the assessment setting, the referral question, and clinician preference and orientation. Still, by 1970, there was a standard battery of tests used in assessment, which typically included an intellectual measure, an objective measure of personality, and projective instrument(s). A *projective* test is aptly termed: It is intended to facilitate the projection of internal psychological organization and needs onto ambiguous stimuli (Morgan & Murray, 1935). Such techniques are thought to help reveal the psyches of those tested, much like an “x-ray” of the inner mind (Lemov, 2011). Although they “originated with a highly specialized and somewhat esoteric group in psychology and psychiatry” (Spindler, 1962, p. 1326–1327), this changed with the terrain of World War II.

As people became more interested in both social dynamics and individual differences, the *projective test movement* (Lemov, 2011) took off. This period saw a rapid increase in the number of projective tests and their frequency of use, as well as in the persons who considered them an acceptable medium for exploring the psyche (Lemov, 2011; Lubin et al., 1971). Parallel to the development of projective techniques, the mid-20th century saw objective measures of personality gain favor. This can largely be attributed to the development of the Minnesota Multiphasic Personality Inventory (MMPI)—an empirically derived personality measure.

The standard assessment battery described above endured without significant challenge until the 1970s. Around that time, the use of both projective and objective measures came under fire (Butcher, 2010; Groth-Marnat, 2000; Korchin & Schuldberg, 1981). As mentioned above, the psychometric tradition strongly valued test reliability and validity; it also questioned the use of less-structured projective stimuli. The rise of behaviorism and humanistic psychology further complicated the field of clinical assessment (Finn & Tonsager, 1997; Korchin & Schuldberg, 1981). Although the behavioral and humanistic approaches are antithetical in many ways, both

objected ideologically to psychological testing. Behavioral psychologists questioned the validity of many tests, as well as the relevance of understanding unique (and unobservable) dynamics. They also introduced behavioral assessment, which veered away from exploring why people act as they do and instead focused on what behaviors people engage in, when and where (Groth-Marnat, 2000; Korchin & Schulberg, 1981). On the other hand, humanistic psychologists were interested in “the meanings people give to their lives and to the world around them,” rather than individual traits and behaviors (Korchin & Schulberg, 1981, p. 1148). They criticized traditional testing as reductionistic and objectifying in nature. They also challenged the hierarchical nature of the traditional assessor–client relationship, instead emphasizing collaboration and transparency.

Skepticism has not only arisen from the behavioral and humanistic camps of psychology. Irrespective of theoretical orientation, many psychologists have argued that clinical assessment overpathologizes clients and, further, does not accurately reflect or represent “real world” functioning (Groth-Marnat, 2000). The message of disfavor also appears to have spread within academia. According to Korchin and Schulberg (1981), “graduate programs reduced their emphasis on clinical testing as faculties saw less of value in it...despite the fact that these views may not have been shared by clinicians” (p 1149). In addition, the field has and continues to face challenges from external forces, including managed health care (Groth-Marnat, 2000; Krishnamurthy et al., 2004). Managed care organizations are becoming more reluctant to pay for comprehensive psychological batteries and the cost of such testing is prohibitive for most individuals and families. Groth-Marnat asserts that “at the core of managed health care’s concerns with assessment is that it is not financially efficient” (p. 355). Although these and other

criticisms have certainly affected the field of assessment as a whole, the growing dissatisfaction with testing as usual afforded the emergence of alternative approaches, as discussed below.

Collaborative and therapeutic assessment. While many psychologists adhere to the aforementioned information-gathering approach, a growing number of assessment psychologists are applying collaborative and therapeutic assessment practices. In doing so, they are working collaboratively with their clients and striving to intervene and make change in their clients' lives. The early history of such practices arose, at least in part, from the appeal of humanistic psychologists to reduce the power differential between treatment provider and client, to enhance empathy, and to contextualize client information (Finn & Tonsager, 1997). Constance Fischer, a pioneer in collaborative assessment who later developed a comprehensive model of assessment (most recently termed *collaborative, individualized assessment* [2000]), endeavored to individualize the testing process and to foster change in those assessed. In her approach, Fischer (2000) applied key principals in phenomenological psychology to assessment. She regarded the contextualization of clients as particularly important, maintaining that all people are "in lively flux" and not "an assemblage of traits" (p. 4). In addition to advocating for test data to be translated into the context of clients' everyday lives (i.e., contextualization), Fischer sought continual client collaboration, including throughout the feedback process. Per Fischer, those of her early writings that focused on feedback provision were initially denied by journals (personal communication, June 4, 2012).

In recent times, such efforts to collaborate and intervene have developed into multiple distinct models of psychological assessment (e.g., Stephen Finn's *Therapeutic Assessment* and Hilsenroth's Therapeutic Model of Assessment). As stated above, collaborative and therapeutic assessment approaches will be jointly referred to as C/TA. In C/TA models, the relationship

between the assessor and the client shifts. The assessor is not seen as a detached, skilled technician but as a professional who plays an active role in the assessment process, is a facilitator of change, and whose personality and past experiences affect the process (Finn & Tonsager, 1997). Whereas the traditional role is “objective observer,” that of a collaborative assessor is “participant–observer” (Finn & Tonsager, 1997, p. 378). Glasser (2007) stressed how this approach to assessment compels psychologists to apply skills from multiple training domains, including psychotherapy skills to attune to the individual in and outside the room.

As implied above, in C/TA the assessment clients are seen as active contributors in the process. They are encouraged to share their thoughts throughout the assessment, including during goal setting, interpretation, and feedback (Finn & Tonsager, 1997; Tharinger, Finn, & Hersh et al., 2008). Individualized feedback is an essential component of C/TA approaches, and one that many within the C/TA community have called attention to and investigated (i.e., Fischer, Finn, Handler, Tharinger, and so forth). According to De Saeger et al. (2014), *individualized feedback* “implies that the normative test data are translated into the idiographic context of the client’s everyday life” (p. 478). Above all, Finn’s early work concentrated on “how to make feedback from psychological assessments therapeutic” (Finn et al., 2012, p. 4). In doing so, he collaborated with others, such as Fischer, and later with Handler and Swann, to develop a systematic approach to presenting assessment impressions. Finn is now recognized as the principal developer of Therapeutic Assessment (TA; capitals “T” and “A”).

Therapeutic Assessment. Within the field of collaborative assessment, TA is a semi-structured approach to testing, which functions as a hybrid of psychological assessment and short-term therapeutic intervention. TA, as coined by Stephen Finn (2007), refers to a specific theory, collaborative style, and set of techniques. The primary goal is to facilitate positive

change, not to diagnose disorders or plan treatment (as in the information-gathering model). The model includes a series of sequential steps that typically span several months. As stated by Finn et al. (2012): “This structure is not seen as fixed or absolute, however...It can and should be altered to fit each client and setting” (p. 5–6). A modified structure is especially indicated for children and adolescents; these methods termed TA-C and TA-A, respectively, and are discussed below.

Assessment feedback. Given the varied conceptions of psychological assessment described above, it should come as no surprise that the field also diverges in its approach to test feedback. The traditional line of thinking within the field was that feedback should not be shared with the individual assessed, as it could cause harm and “...much grief, both to the patient and to the psychologist” (Klopfer, 1954, p. 603). In his classic paper on psychological report writing, Klopfer recommended that assessors, when faced with client pressure to share results, provide “superficial kinds of interpretation” that are “not particularly anxiety-provoking” (p. 603). Others have similarly argued that sharing test results can confuse, overwhelm, and discourage clients (Brodsky, 1972; Finn & Tonsager, 1992; Klopfer, 1954). Thus, potentially in an effort to circumvent such deleterious effects, client-directed feedback was withheld and the exchange of test information was primarily between professionals (Finn & Tonsager, 1997).

In an early paper, Fischer (1972) expanded upon the potential motives of clinicians to withhold test results from clients, and grounded such motives historically. She suggested that the practice of withholding test findings is rooted in the field of psychology’s foundations in natural science. From that perspective, clinicians acquire client “truths” through the use of scientific method, particularly objective observation and measurement. They are able to develop said truths and make helpful decisions because, as “experts,” they can employ deductive interpretation of

assessment data. Few would disagree that good data interpretation requires specialized training and skill; however, Fischer (1972) argued that *absence* of specialized training should not preclude the client from being privy to assessment results. In fact, she proposed a paradigm shift: away from a natural science approach and toward a human (structural) science approach, in which the client is a co-assessor, his or her world-view is critical to the evaluation, and “truths” are subjective. Relatedly, and in the same set of articles, Brodsky (1972) argued that clients should have the right to access their own files and to comment on all reports. He also dispelled some of the assumptions for maintaining this “procedure of secrecy” (p. 362). Thus, as early as 1972, authors were challenging the assumption that feedback should be provided only by merit of professional training and were championing for feedback to be shared with clients.

Although some clinicians may purposely refrain from providing feedback, others may simply be unaware of its potential utility or feel unprepared to communicate the results effectively (Butcher, 1992; Curry & Hanson, 2010; Finn & Tonsager, 1997). Butcher (1992) proposed that many clinicians lack specialized training in feedback techniques. This supposition was empirically supported by Curry and Hanson. The authors, who surveyed nearly 500 doctoral-level psychologists about their training in providing assessment feedback, found that 35.6% received “very little” or “none at all” training prior to internship. Also, in a survey study of assessment course instructors by Rupert et al. (1999), results indicated that most instructors have no policy regarding feedback provision to “practice” subjects. Despite the authors providing some reasoning for this procedural lapse (e.g., concerns with student competency), the finding still suggests a de-emphasis on the feedback process in graduate education. In addition, a review of the literature reveals only a few frameworks for providing feedback to clients, all published in the last 20 or so years. Many of the popular textbooks on psychological assessment

also clearly lack attention to feedback. It can be inferred, then, that a large number of currently practicing assessors were not trained, at least while in graduate school, on specific feedback approaches.

Even for those clinicians who have a framework and/or believe in feedback's utility, the provision of negative results (e.g., information that is ego dystonic, suggest a poor prognosis, etc.) can pose particular challenges (Smith & Finn, 2014). Assessors are often tasked with the difficult job of discussing test findings that are counter to a person's self-view, while attempting to maintain trust and enhance understanding. To do so requires skill and effort, as well as a repertoire of language to fit each client's competence. Relatedly, as Gass and Brown (1992) elucidated, providing test feedback from a neuropsychological assessment can present its own obstacles. The challenge of describing results to individuals who present with cognitive impairments is just one example. Additionally, some clinicians may fail to share impressions with the client due to the possibility of being rebuffed. The discomfort that can accompany rejection is not lost on clinicians. Newer assessors may be especially hesitant to open themselves up to reproach, as well as to the challenging questions that can arise during feedback sessions.

Issues concerning monetary coverage may also discourage clinicians from providing personalized test feedback. In a field that has become increasingly beholden to managed care and associated reimbursement struggles (Finn, 2007; Groth-Marnat, 2000; Piotrowski, 1999), every minute of service counts. This is especially true for clinicians who seek compensation from health insurance companies. Coverage, reimbursement rates, and the way in which insurance plans compensate for psychological testing vary across companies and states. Many require pre-authorization, pay by unit, and have a cap on the number of units of service per psychological assessment. Others offer an established rate—one that does not necessarily

allocate time for a comprehensive feedback session, or sessions in the case of a child assessee (Pope, 1992). In the APA's Monitor on Psychology, Daw (2001) reported "most reimbursement issues crop up around the amount of time needed to perform assessments. The time allocated by third-party payers to administer, score and interpret tests can be less than needed to simply administer a test" (p. 46).

Clinicians may be even less prepared to discuss assessment results with children and adolescents. The paucity of literature in this area makes it difficult for even interested practitioners to learn pragmatic techniques and develop conceptual approaches (Tharinger, Finn, & Wilkinson et al., 2008; Tharinger & Pilgrim, 2012). Assessor uneasiness may also arise due to past, discouraging experiences in sharing results with children, such as receiving blank starts, uninterested commentary, and expressions of overwhelm. Tharinger, Finn, & Hersh et al. (2008) suggest that these experiences may leave practitioners "feeling ineffective and vulnerable in their relationship with the child and may have curtailed or eliminated altogether the practice of telling children about assessment results (focusing only on parent-directed feedback)" (p. 611). The authors argue, though, that such reactions should not prevent the practice but encourage a modification in approach—an approach that reflects a child's emotional and cognitive capacities.

Clearly there are, and have long been, multiple barriers to the provision of client-directed feedback. Still, the literature suggests a shift toward placing increased value on the feedback process. This shift was, in part, shaped by changes made to the APA ethical guidelines. In 1970, the APA published a public policy statement that affirmed the right of those assessed to be informed of who will have access to their results. It did not yet, however, address the assessee's own rights to such information. In an influential article published shortly after APA's statement, Brodsky (1972) called for a reexamination of procedures related to clients' rights to access their

records and encouraged clinicians to share test results with clients. It was not until 1992, though, that the APA published an ethical standard on assessment feedback. Specifically, this standard asserted that unless the nature of the testing relationship precludes feedback, “psychologists ensure that an explanation of the results is provided using language that is reasonably understandable to the person assessed or to another legally authorized person on behalf of the client” (APA, 1992, p. 1604). Although APA’s newfound emphasis on client feedback surely contributed to its rise in acceptability, the importance of this endeavor was exemplified decades prior by a number of clinicians who were already routinely sharing test feedback with clients and, perhaps more importantly, reporting on the therapeutic benefits of doing so (Berg, 1985; Finn, 1996; Finn & Tonsager, 1992; Fischer, 1972). As discussed above, this generation of psychologists (some collective and others separate) argued that clinical assessments should include the proviso of verbal feedback, and “results” should be shared in a manner that is meaningful to the client, including child and adolescent assessees (Finn & Tonsager, 1997; Tharinger, Finn, & Hersh et al., 2008).

Despite existing ethical guidelines (APA, 2010), the literature suggests that the manner by which clinicians provide client feedback varies substantially. This likely depends, at least in part, on the clinician’s approach to assessment and his or her view of client-directed test feedback: as simply perfunctory, as fundamental to an assessment, or somewhere in between. Those who typically adhere to an information-gathering approach to testing, for example, appear to align more with the former view (i.e., feedback as pro forma). Such assessors are more likely to present test results in a unilateral, factual manner (Finn & Tonsager, 1997). In contrast, clinicians inclined toward therapeutic models of assessment endeavor to engage clients in an

open-ended dialogue about the test impressions (Finn & Tonsager, 1997; Newman & Greenway, 1997).

Assessment feedback in TA. In TA, test feedback is shared during the “summary/discussion session”—the process of which is considered a short-term intervention (Glasser, 2007). Impressions are shared interactively, inviting assessees to attest to and/or offer disparate ideas. Despite the open dialogue, feedback sessions are still rather organized. In TA, the approach to feedback is level-driven (elaborated on in Tharinger, Finn, & Wilkinson et al., 2008), and further organized by the client’s assessment questions. In terms of being level-driven, findings are categorized into “Levels of Information” and provided in an order that corresponds to the client’s existing narrative, with the information most similar to their self-view (Level 1) shared first and most discrepant (Level 3) shared last (Finn et al., 2012; Smith & Finn, 2014). It is presumed that Level 1 information validates the client’s reality and is the least likely to provoke anxiety, whereas Level 3 elicits some distress and “mobilizes [the client’s] characteristic coping mechanisms” (Smith & Finn, 2014, p. 409). Also per Smith and Finn, “the ordering of feedback from L1 to L2 to L3 is one way of titrating clients’ emotional arousal by helping them feel understood and supported by the assessor” (p. 409). There is also substantial evidence suggesting therapeutic benefits to this approach (Hamilton et al., 2009; Schroeder, Hahn, Finn, & Swann, 1993; Tharinger, Finn, & Hersh et al., 2008). In addition, the results are contextualized for the client and linked back to the original assessment questions. Toward the end of the feedback session, clients are usually asked to summarize their understanding of the results, as well as their experience of the assessment more generally.

Assessment feedback with children. Traditional assessment procedures do not include the provision of child-directed feedback. Results are more typically shared with the parent(s) or

caregiver(s) of the minor. TA, however, includes both parent/caregiver and child-directed feedback sessions, with the child session occurring subsequent to the parent session. Finn, Tharinger, and colleagues at the TAP maintain that children, like adults, benefit from developing new understandings of themselves, and that hearing thoughtful feedback can be instrumental in this process (S. E. Finn, personal communication, June 7, 2012). They also maintain that findings should be relayed in a manner that accounts for a child's developmental capacities. Tharinger, Finn, & Hersh et al. (2008) propose that in order to provide digestible and helpful feedback one must consider the child's educational level, cognitive abilities, cultural background, and family structure. They warn against providing too much content, or information that is directly focused on their problems, as this can elicit overwhelm and confusion. Rather, the session typically focuses on the child's strengths and Level 1 and 2 findings. It is also recommended that prior to the child-directed session the assessor seeks parental input on how to best present the findings. Although parents typically attend the feedback sessions of young children, their presence is more discretionary with older children and at times discouraged with adolescents (Tharinger, Finn, & Wilkinson et al., 2008). With parents in attendance, feedback sessions can function as a brief family therapy intervention (Glasser, 2007).

In TA-C, test feedback is often presented to the child using the medium of fable. That is, assessors write an individualized fable that is intended to metaphorically describe the findings of the assessment, and then present the fable during the child-directed feedback session. This approach was first employed by Fischer and later adopted by Finn (Finn et al., 2012). It is proposed that this allows for an individualized, sensitive, and developmentally appropriate presentation of testing results. Tharinger, Finn, & Wilkinson et al. (2008) present a particularly compelling rationale for using fables, stemming from a long, positive history of their use with

children in psychotherapy. The authors, who present a case to illustrate the development and presentation of a fable, suggest that fables allow symbolic meaning to be imparted on children in a way that is appreciative of their reality and engagement with the fantasy world. According to the authors, “using the realm of fable and fantasy can assist children in taking in the new story without overtaxing their mental and emotional capabilities or raising their defenses” (p. 612). Also, because assesseees are given their written fables at the conclusion of a TA, they can continually refer back to the story. It can also serve as a transitional object. Of note, TA-C is not the only published model for providing feedback to children. For example, Becker, Yehia, Donatelli, and Santiago (2002) described how they develop and provide child clients with therapeutic, illustrated storybooks as feedback at their center in Brazil.

Although the use of feedback fables is common practice in TA-C, adolescents are sometimes also provided with a story (Finn, 2007). This often depends on the assessee’s developmental capacities, as well as assessor style and preference. More often, typically developing teenagers are provided with oral feedback as well as written results in the form of a letter, as is done with adult assesseees (Finn, 2007; Tharinger, Gentry, & Finn, 2013). In many cases, a more traditional report is also indicated and thus provided, such as for a school or psychiatrist. In terms of oral feedback, S. E. Finn (personal communication, June 5, 2012) recommended first meeting with the adolescent alone and answering his or her assessment questions. Toivakka (2012) suggested that when conducting oral TA-A feedback sessions, clinicians “speak about the results using a modification of externalizing conversations” (p. 338). She stated that this is a way to preserve the teenager’s own sense of identity rather than directly saying, “You are like this” (p. 338). Also, S. E. Finn recommended asking the adolescent for input on how to discuss results with the parent(s).

With regards to language, TA and all C/TA models underscore the importance of speaking (and writing) clearly to clients. The words used, and implications of said words, are meant to be understood by the client, for both clinical and ethical reasons. Also, as discussed by Gass and Brown (1992), to deny a client *comprehensible* feedback is to ignore their considerable investment. So, how do clinicians ensure that their feedback is comprehensible? Many of the influential C/TA publications recommend using plain language and avoiding technical jargon and statistics. Fischer (1972) has encouraged clinicians to use the client's own language since 1972, such as "hibernating" rather than "withdrawing" (p. 367). Finn has frequently remarked on the value in using metaphor (Finn, 1996; Finn, 2007; Smith & Finn, 2014), especially those that emerge on clients' projective test material (Finn, 2007; S. E. Finn, personal communication, June 7, 2012). Gorske (2008), who presented a humanistic model for neuropsychological feedback, stressed applying test results to everyday functioning, particularly when concerning complex cognitive skills.

The utility of assessment feedback. In addition to aiding in accurate diagnosis and treatment planning, mounting research suggests that psychological assessment has the potential to facilitate positive change and improve individual functioning. Although multiple factors likely contribute to such positive effects, this section will focus on research that has examined test feedback; first with adults and then with child and adolescent assessees. The scholarship in this area is rather limited and primarily comes from the field of C/TA, with a majority accruing in the past twenty years. However, as early as 1963 at least one researcher (e.g., Wright) was completing randomized, between-group comparisons of people who had and had not received feedback following an assessment, and the findings were promising. Specifically, the Wright (1963) study compared college students who received feedback on test results (i.e., "test

interpretation interviews” [p. 126]) to those who did not; both groups completed the same freshman guidance test. The author compared the two groups on multiple measures of self-rating accuracy and, given statistically significant differences, concluded that test feedback contributes to better self-understanding.

An extensive review of the literature found three other studies that included similar between group comparisons, all of which utilized a collaborative model of assessment when providing feedback. First, Newman and Greenway (1997) looked at the therapeutic effects of sharing MMPI-2 test results with college students. The authors found that providing personalized results to clients resulted in a significant increase in self-esteem and decline in symptomatic distress. A second study (Allen, Montgomery, Tubman, Frazier, & Escovar, 2003) aimed to extend this line of research by investigating the impact of assessment feedback on rapport building and self-enhancement—two processes that have been suggested in the literature to inspire therapeutic change. Here, both groups of subjects were asked to complete the Millon Index of Personality Styles, a 180-item self-report questionnaire. Results of the study supported the authors’ hypotheses regarding rapport; that is, “participants receiving feedback following an assessment felt a stronger rapport with their examiner... they also rated the information they received following their assessment as significantly more valuable than participants receiving only general information” (p. 176). Results relating to self-enhancement, assessed via four unique measures, were more mixed though generally suggested that personalized feedback enhances examinees’ sense of self and personal regard.

The third study by Aldea, Rice, Gormley, and Rojas (2010) was similar to that of Newman and Greenway (1997) but included a sample of “maladaptive perfectionists.” The authors aimed to answer the question: “Does explaining test results affect the emotional

self-regulation, self-esteem, and psychological distress of maladaptive perfectionists?” In this study, 60 young adults who were identified as perfectionists via a prescreening process were randomly assigned to either the control group or to the feedback intervention group. Results revealed that participants who received feedback about their perfectionism, compared with those who did not, reported a reduction in symptomatic distress and in emotional reactivity. The authors found no differences, however, in self-esteem between the two groups.

The Newman and Greenway (1997) study mentioned above was, in part, a response to an earlier study conducted by Finn and Tonsager (1992). In what appears to be the first systematic study of a collaborative model of assessment, Finn and Tonsager (1992) investigated the therapeutic effects of receiving assessment feedback. They did so by comparing groups of college students who took the MMPI-2 and received verbal, personalized feedback to those who received only examiner attention. Results showed significant therapeutic effects associated with feedback, including reductions in client symptomatology, increased feelings of hope, and improvements in self-esteem. However, this study had a notable limitation in design: The controls did not complete the MMPI-2, and thus the authors were unable to definitively report that it was the feedback that led to therapeutic benefit. This was modified in the Newman and Greenway (1997) study, in that all participants completed the stimulus; results supported Finn and Tonsager’s (1992) findings.

Poston and Hanson (2010) conducted a meta-analysis to examine psychological assessment as a therapeutic intervention (abbreviated PATI in the authors’ subsequent publication). This meta-analysis included 17 studies published between 1954 and 2007, and aimed to address the research question: “Does psychological testing, when combined with personalized, collaborative feedback of some sort, affect treatment processes and outcomes and,

ultimately, benefit clients?” (p. 204). The results, given a statistically significant and robust effect size (Cohen’s $d = .42$), strongly supported the clinical efficacy of assessment procedures when provided in conjunction with individualized feedback. Per the authors, an additional (and unexpected) finding was revealed when they looked at the “research design” variable: The difference between studies that used control groups versus comparison groups was not significant. With this information, the authors inferred “assessment and testing as usual (e.g., an information-gathering approach) and/or testing without feedback may be as therapeutically inert—in terms of treatment processes and outcome—as receiving no treatment at all” (p. 210). Thus, on the basis of their meta-analytic findings, feedback can be considered a critical component to achieving client change. It is also of note that, upon responding to commentary by Lilienfeld, Garb, and Wood (2011) and re-analyzing the data accordingly, Hanson and Poston (2011) again found a significant effect size for PATI.

In addition to improved functioning, research has demonstrated that sharing feedback in a well-formulated and collaborative manner correlates with a stronger working alliance and continuation of services (Ackerman et al., 2000). Specifically, Ackerman et al. compared two groups receiving psychological assessment services, one from a therapeutic assessment model and the other from an information-gathering approach. Both groups received a feedback session in line with the respective assessment approach. Participants who received the therapeutic assessment not only demonstrated stronger alliance with their assessor but also with subsequent psychotherapists. Additionally, the ratings of the feedback session’s quality were highly related to the depth of the session. The authors concluded: “These findings suggest that the clinician does not have to minimize the patient’s problems or sugarcoat the assessment feedback for the patient to feel that the session was good” (Ackerman et al., 2000, p. 104).

Researchers have also used time-series designs to look at the process of assessment and at what point change occurs, if at all. Although such methodology has primarily been applied to single-case studies, a study conducted by Holm-Denoma et al. (2008) looked at 53 adult outpatients who were provided a diagnostic assessment and comprehensive feedback. Results indicated a significant increase in positive emotions (e.g., hope and validation) following the provision of diagnostic feedback (i.e., between the beginning and the end of a feedback session). There was no significant change in negative emotions (e.g., shame and fear). The authors concluded that feedback does not increase client distress—a finding similar to the abovementioned Ackerman et al. study (2000). In terms of time-series designs of single-case studies, results have further suggested improvement from baseline to post-assessment of a TA, but not specifically following feedback provision (e.g., Aschieri & Smith, 2012; Smith & George, 2012).

In addition to the empirical studies described above, many authors have drawn upon extensive clinical experiences to detail observed client benefits following assessment feedback. Finn (1996) reviews many of these earlier writings, with benefits including decreased symptomatology and increased hope, self-esteem, and self-understanding. More recently, case examples have illustrated client gains such as enhanced self-compassion (Tarocchi, Aschiere, Fantini, & Smith, 2013) and self-acceptance (e.g., a shift in self-view from “a stupid, horrible woman who couldn’t finish anything in life” to a “survivor of traumatic events” [Aschieri & Smith, 2012, p.6]).

Research has also suggested therapeutic benefits to sharing test feedback with individuals who completed neuropsychological testing (Gorske, 2008; Gorske & Smith, 2012; Pegg et al., 2005). For example, Gorske and Smith (2012), who utilize motivational interviewing techniques

to present feedback in their *Collaborative Therapeutic Neuropsychological Assessment* (CTNA) model, describe a case study of an adult with a severe brain injury who, following feedback from a CTNA, demonstrated improved self-insight and greater engagement in his rehabilitation program. Likewise, an earlier study conducted by Pegg et al. found positive effects from sharing personalized neuropsychological test results with rehabilitation patients, including an increase in treatment satisfaction and effort.

Evidence for the utility of feedback with children. A review of the literature reveals that few studies have directly examined the effects of child-directed assessment feedback. In other words, there is sparse research published on how receiving test feedback impacts a child assessee. One between-group study was found: Tharinger and Pilgrim (2012) evaluated 32 children who underwent neuropsychological testing and then completed an exploratory questionnaire about the assessment experience. Here, “the groups differed on only one variable: whether or not the child, accompanied by parents, received individualized feedback in the form of a fable” (p. 229). The parents of children in both groups received feedback. Findings indicated that the children who received personalized feedback (i.e., the experimental group) reported a greater sense of self-understanding than those who did not. In addition, both the child clients and their parents reported greater collaboration and rapport with the assessor. These findings are promising, suggesting that fables can be used to relay assessment information to children in a way that is meaningful, develops awareness, and enhances rapport. Also, given results that the parents of the experimental group were more satisfied with the testing services, there may be customer satisfaction implications to this research.

Within the field of C/TA, research and case studies with assessees under the age of 18 are accruing. To date, findings largely support the clinical utility of C/TA approaches and often

highlight the child-directed feedback process as a mechanism of change. For example, the TAP published a pilot study of TA-C in 2007 that used a repeated measures design and included 14 children who were clinically referred due to emotional and behavioral challenges (Tharinger, Finn, Wilkinson, & Schaber, 2007). Based on preoutcome-postoutcome data, results demonstrated decreased child symptomatology and enhanced family connection, as reported by both children and mothers. More specifically, the results of maternal report revealed decreased maladaptive behaviors (both internalizing and externalizing), increased family functioning, increased positive emotions about their child, and decreased negative emotions about their child. The self-report of the child participants also indicated a significant decline in maladjustment and increase in family connection following the TA-C. Findings suggest that children and their families can benefit greatly from collaborative assessment and personalized feedback. In this study, each of the children were provided with a personalized fable and the criticalness of good feedback was addressed; however, feedback was not independently examined.

Relatedly, Smith, Handler, and Nash (2010) conducted a time-series design study of TA-C that included three preadolescent boys who were diagnosed with Oppositional Defiant Disorder and their families. Results indicated a reduction in client symptoms, but at different points in time. In one case, the symptomatic improvement directly followed the provision of feedback. In another time-series study, Smith, Wolf, Handler, and Nash (2009) used a single case to examine the benefits of family TA. Results here largely supported the course of change initially proposed by Finn (2007), in that the child began to experience, from the parents' perspective, symptomatic improvement early on in the TA and that benefits continued throughout the process and beyond completion of the assessment. Although change unfolded

throughout the assessment, and not solely after the feedback session, the authors noted the need for aggregate research on the distinctive components of the TA model.

With respect to published clinical case studies of TA with children and adolescents, numerous authors have reported multiple benefits (Becker et al., 2002; Finn, 2007; Gorske & Smith, 2012; Hamilton et al., 2009; Pollak, 1988; Purves, 2002; Smith & Handler, 2009; Tharinger et al., 2007; Tharinger et al., 2009; Tharinger, Finn, & Wilkinson et al., 2008), including improved mood, improved social functioning, increased self-esteem, increased self-understanding, decreased behavioral problems, increased parent understanding of child, and enhanced family functioning. It has also been postulated that the promise of feedback from the outset can enhance a child's level of engagement throughout the assessment process (Tharinger, Finn, & Hersh et al., 2008).

In most of the research and clinical studies discussed above, the parents provided indication of benefits, rather than the child. However, a few studies have attempted to gain an understanding of the child assessee's experience through direct inquiry, including the aforementioned study by Tharinger and Pilgrim (2012). Also, in the research and clinical case study detailed by Tharinger et al. (2007), the team tracked the child's process weekly during the TA using both quantitative and qualitative measures. The child's report indicated that she "felt more hopeful and better about herself and also perceived a decrease in family conflict and an increase in family communication" (p. 305). Likewise, Hamilton et al. (2009) gathered research data from their 8-year-old client pre- and post-TA-C; results indicated a decrease in symptomatology and family conflict. However, in each of these studies the feedback session was not specifically investigated.

As with the adult client population, multiple practitioners have described their clinical experiences in providing feedback to children and adolescents. This discourse even preceded the development of C/TA models. For example, Colley (1973) discussed how providing test feedback to children resulted, at least anecdotally, in increased ease and happiness. More recently, Fischer and Finn (2014) published transcripts of TA sessions that highlight clients' positive change following feedback sessions. Also, Tharinger, Finn, & Wilkinson et al. (2008) wrote the following of their experience at the TAP:

We have also found that the use of fables helps children feel validated and understood, and that a successful fable seems to provide children with an intense experience of positive accurate mirroring. Our observations fit well with the theoretical underpinnings of narrative development through attachment experiences. We have also seen that children are surprised and pleased that the assessor has written the fable just for them and are touched that the assessor knows them so well and is hopeful for their future. (p. 612)

Overall, the results of multiple studies of TA with children, adolescents, and their families suggest that this approach can be effective in increasing self-esteem and insight, and reducing both individual and family distress. The collective clinical experience of assessors in providing child-directed feedback is also considerable. Although feedback is not the only potential mechanism of change, the existing literature certainly supports further investigation into the practice.

Current standards of feedback practice. In examining the current ethical standards for the provision of assessment feedback, the APA (2010) has a defined position on the necessity of providing clients with assessment results. Specifically, Standard 9.10 of the Ethical Principles of Psychologists and Code of Conduct dictates, “psychologists take reasonable steps to ensure that

explanations of results are given to the individual or designated representative unless the nature of the relationship precludes provision of an explanation of results” (p. 13). The competency benchmarks cited by the APA (2012) also reference the need for effective communication of assessment findings, stating that an entry-level practitioner communicates “results in written and verbal form clearly, constructively, and accurately in a conceptually appropriate manner” (Fouad et al., 2009, p. 18). Also, per the 2014 edition of the Standards for Educational and Psychological Testing (published collaboratively by the American Educational Research Association, the APA, and the National Council on Measurement in Education), assessors should provide testees with some understanding of the tests used and the scores obtained, all in comprehensible language.

Although the intention of the APA and related committees is relatively clear, the language used regarding feedback procedures (e.g., “take reasonable steps”) remains rather ambiguous. What *steps* must a psychologist take to provide feedback? Do results need to be shared verbally, or does a written document suffice? How does one know if the language used is “appropriate?” How much time should be allotted in service of providing feedback? Also absent are ethical guidelines on how to approach the provision of feedback with child and adolescent assesseees. It seems that as long as the parent or guardian of the child tested is the *client* and/or the “designated representative” (APA, 2010, p. 13), psychologists are not ethically required to explain test results to minors. Tharinger and Pilgrim (2012) used the word discretionary (p. 229) to describe the practice of child-directed feedback.

Although there is no consistent explanation for why child-directed feedback is not the norm, those at the TAP (Hamilton et al., 2009; Tharinger et al., 2007; Tharinger, Finn, & Hersh et al., 2008; Tharinger, Finn, & Wilkinson et al., 2008) have suggested the following: (a) the assessor believes that the results are too complex for a child to comprehend, (b) the assessor

believes that the results are too threatening for a child given his or her emotional maturity, and (c) the assessor avoids extra work that is not required by ethical principles. The paucity of literature on methods for sharing feedback with children and adolescents is an additional explanation. Although C/TA approaches have helped to fill this void more recently, historically little has been written on how to deliver test results in a developmentally appropriate manner. There also appears to be little published on the feedback practices of psychologists; that is, with what frequency do assessors share results with their clients, adult or child.

Existing literature on feedback practices. An extensive review of the literature found two studies and one dissertation that examined assessment feedback practices among psychologists. Each of these empirical studies explored, by survey, the frequency with which in-person test feedback is provided to clients. They also each had unique areas of focus (e.g., feedback training and supervision in Curry and Hanson [2010]). None of the three studies, however, directly explored the feedback process with child and adolescent assesseees. Given the relevance of these three studies to the present research, their methods and results are described below.

In what appears to be the first empirical study conducted on psychologists' feedback practices, Peterson (1998) explored the "training, attitudes and practices in the provision of objective personality assessment feedback" (p. iii). In this impressive dissertation-focused research, Peterson gathered data from 482 practicing psychologists who were selected on the basis of their Society for Personality Assessment (SPA) membership; surveys were initially sent via mail to 1500 doctoral level psychologists. Results of the study suggested that 22% of practitioners who conduct personality assessments provide in-person feedback 0–25% of the time, whereas a majority "regularly" share results with the assessee (i.e., 89% in any format;

66.3% orally). However, a much smaller percentage of respondents (i.e., 23%) reported sharing results 100% of the time.

Peterson found that the frequency of feedback varied substantially, with contributing factors such as the clients' age, level of functioning, and resistance. With regard to client age—the variable most relevant to this study—Peterson found that 42% of the practitioners who reported providing feedback less than 100% of the time refrain from doing so because of the assessee's age (i.e., "Client was too young to benefit" [p. 116]). Although follow up questions regarding client age were not asked, 84.2% of the respondents who reported age being a factor also reported regularly sharing feedback with "parents/significant others" (p. 115). Peterson was also curious about assessors' attitudes toward feedback provision, and asked subjects to rate the appropriateness of personality feedback, using a Likert scale, for three defined age groups: (a) adults, (b) adolescents, and (c) children. Results indicated a relatively solid consensus regarding the appropriateness of feedback for both adults and adolescents (response means fell between "agree somewhat" and *strongly agree*). However, opinions were much more varied with respect to child assesseees, with a response mean just above *neutral*. The author proposed that such a divergence in the field may be attributable to the specialized nature of assessing personality characteristics in children, and that the "data presented in this study suggest that experience and training in this area contribute to the development of positive attitudes toward the provision of feedback to these populations" (p. 91). She concluded that child-directed feedback provision is "an area in need of attention" (p. 92).

Nearly 20 years later, Smith et al. (2007) conducted the first peer-reviewed research that focused on assessment feedback practices among psychologists. The authors collected data via Internet survey from 719 practitioners (22% response rate) on both the frequency of feedback

provision and perceived client benefits. Inclusion criteria was membership in the SPA (like Peterson [1998]) and/or in specific neuropsychological organizations. The authors found that 49% of those surveyed reported “always or almost always” providing in-person assessment feedback. This percentage jumped to 71.3% with the inclusion of respondents who *usually* share in-person results with the client. However, information regarding the age of clients was not gathered. An additional finding of relevance, especially when compared to Peterson’s research, was that less than 10% of the respondents *seldom* or *never* provide in-person feedback. Although these two studies used different criteria to assess frequency, this percentage appears to be substantially less than what Peterson found approximately 20 years earlier (22%). This may reflect a paradigm shift toward viewing assessment feedback as important, mandatory, and/or beneficial to clients.

The most recent study to examine test feedback practices was published by Curry and Hanson (2010). The authors similarly conducted a survey of practicing psychologists. Quantitative data was collected on 468 participants (48.5% response rate), each of whom held APA membership and had identified an interest in testing on their APA profiles. The authors also used follow-up phone interviews to collect qualitative data from a sample of the survey participants. The authors found that 35% of the total respondents provide verbal feedback “every time,” with an additional 30.6% *usually* providing it. Results here are relatively similar to the study conducted by Smith et al. (2007). Likewise, 7.9% of the sample indicated that they rarely or never provide verbal feedback, which is slightly less than Smith et al.’s (2007) finding of 9.5%. Although a majority of the respondents indicated at least some assessment of children and adolescents (70.1% and 78.6%, respectively), they were not asked to differentiate between these populations and adult assessees in terms of the methods used to provide feedback or the

frequency with which they do so. The data collected also did not allow for analysis of child-directed versus parent-directed feedback provision. However, the authors acknowledged limitations in this area and, like Peterson 20 years earlier, recommended that future research include examination of assessment practices with younger assessees. Specifically, Curry and Hanson advised: “Future studies in this area should explore how individuals provide feedback differently for different types of clients...Asking them how they provide feedback to clients who are younger versus older would also likely be useful and informative” (p. 335).

Rationale for the present study. It is an important time for psychological assessment, the clinical practice that has long distinguished psychologists’ professional identity. Despite substantial and mounting evidence in support of its utility (e.g., the summary study by Meyer et al. (2001) that found it “comparable to medical test validity” [p. 128]), the practice of assessment appears to be facing a number of challenges (Butcher, 2006; Cashel, 2002; Curry & Hanson, 2010; Eisman et al., 2000; Krishnamurthy et al., 2004). Although there are certainly criticisms from within the field of psychology, those originating from outside seem particularly threatening to the practice; namely, the cost-conscious managed care organizations. Several studies have indicated that the practice of assessment has been adversely affected by the financial and temporal limitations set forth by managed care organizations (Cashel, 2002; Eisman et al., 2000; Piotrowski, Belter, & Keller, 1998; Tarocchi et al., 2013). There has also been a documented decline in assessment activities among clinical psychologists from 1986 to 2010 (Norcross & Karpiak, 2012). With a changing health service field and increasing risk of assessment being underutilized, the need for research focused on assessment activities is great. As Gelso and Fretz (2001) so artfully stated, “Our research in the coming decades will help decide whether

psychological assessment is our dodo bird or a phoenix rising from the ‘ashes’ of the critiques of recent decades” (p. 400).

Statement of the problem. Many of the authors cited in this dissertation, and likely elsewhere, have acknowledged the need for aggregate data in the field of psychological assessment feedback (e.g., Cashel, 2002; Curry & Hanson, 2010; Tharinger et al., 2007; Smith et al., 2010). The paucity of scholarship regarding how psychologists manage *child-directed* feedback suggests a particularly valuable area for exploration. This study was designed to address deficits in knowledge regarding the current feedback practices and perspectives of psychologists who conduct assessments with children and/or adolescents, as well as to examine the relationships between feedback provision and selected variables. Such variables include client characteristics (e.g., assessee age group), respondent characteristics (e.g., past training in the delivery of feedback, current practice setting, graduation year), and respondent attitudes (perception of feedback as beneficial or harmful, perception on ethical responsibility to provide feedback). Each of the variables were selected based on the relevant literature.

Purpose of the study. The overarching purpose of this research was to explore the feedback practices of psychologists who conduct psychological assessments with children and adolescents. The survey was specifically designed to gather information on (a) the perceived effects of client-directed feedback, (b) the potential barriers to feedback, (c) past training in the delivery of feedback, and (d) how these aspects of feedback differ as a function of assessee age. The study also aimed to explore factors that may impact the provision of child-directed feedback, such as respondent training and demographics. While the survey was largely designed to gather this and other related information, it was conceived from a perspective that child-directed feedback, though valuable, is often disregarded; a perspective in line with several psychologists

and particularly supported by the C/TA literature. This research purposed to be informative while also encouraging transformations in the feedback practices of psychologists who assess children and adolescents.

Specifically, this quantitative study intended to explore the following research questions:

1. How often do psychologists provide verbal assessment feedback to the parent(s)/caregiver(s) of child and adolescent assessees?
2. How often do psychologists provide verbal assessment feedback directly to assessed minors?
3. What factors are associated with providing assessment feedback to children and adolescents?
4. What are the reasons psychologists name for providing children (ages ≤ 11), adolescents (ages 12-17), and parents/caregivers with assessment feedback?
5. What are the reasons psychologists name for refraining from or withholding assessment feedback to children (ages ≤ 11), adolescents (ages 12-17), and parents/caregivers?
6. Do psychologists feel that they received sufficient training in client-directed assessment feedback?
7. What is the relationship between sufficiency with past feedback training and the extent to which psychologists currently provide feedback?

The following hypothesis were made:

1. Most respondents will report regularly sharing test results with clients.
 - a. These respondents will report sharing test results more often to adult parents/caregivers than assessed minors.

2. Inclusion in feedback sessions will vary by assessee age.
3. Utilization of collaborative and therapeutic assessment practices will be positively correlated with feedback provision to both children and adolescents.

Methods

To address deficits in knowledge regarding the current feedback practices and perspectives of psychologists who conduct assessments with children, a quantitative methodology was chosen. In this section, the methodology and procedures used to gather data are presented including descriptions of the respondents, survey instrument design, data collection strategies, and data analytic procedures.

Participants

Study respondents included psychologists who perform assessments with children and/or adolescents. They were recruited via email, listservs, or web post following approval from Antioch University New England's Institutional Review Board. Each recruitment letter included a brief description of the study; a link to the online, anonymous survey; and instructions on how to consent to the research (see below for more detail). Potential participants were recruited via the following avenues:

- The American Board of Professional Psychology (ABPP) online membership directory, which is publicly available. Recruitment emails were sent to practitioners board certified in the specialties of Clinical Child and Adolescent, Pediatric Clinical Neuropsychology, and School Psychology.
- The APA Division 42 (Independent Practice) listserv.
- The NPSYCH listserv, a pediatric neuropsychology-focused listserv.

- The APA Division 16 (School Psychology) official Facebook page, which the division deems as the most appropriate forum for research requests.

Of note, an effort was made to recruit participants from varied specialty areas (both in and outside of the APA) relevant to this research (e.g., child and adolescent clinical psychology, personality assessment, neuropsychology, school psychology). This recruitment approach was intended to help enhance fittingness of the sample to the research, while also procuring views not likely attainable by surveying only one group or list. With regard to the listservs utilized, recruitment messages were only submitted following approval from the respective Webmasters.

Respondent characteristics. The survey specifically requested participation from psychologists engaged in some form of assessment with children and/or adolescents. A total of 147 surveys were recorded. Five were excluded from analysis as they either failed to answer the screening item or indicated that they do not conduct child or adolescent assessments. An additional three were excluded as a majority of their responses were missing. After exclusion criteria was applied, the final sample included 139 records. General demographic information for the respondents has been summarized in Table 1. Briefly, the sample consisted of 104 (76.5%) females and 31 (22.8%) males; one respondent selected *not listed*. In terms of field of study, 58.8% of the sample indicated that they specialized in clinical psychology; 18.4% in neuropsychology; 12.5% in school psychology; and 5.2% in counseling psychology. The remaining 5.2% of respondents indicated that their field of study was either dual emphasis (e.g., clinical and neuropsychology) or other specialization (e.g., biopsychology, forensic). Respondents graduated between the years of 1970 and 2018. As detailed below, graduation years were divided into intervals by decade (e.g., 1980–1989). The majority of the sample self-identified as White/European American (85.9%), followed by Other (3.7%), Non-Hispanic

Multi-Ethnic (3.7%), African American/Black (3.0%), Asian (2.2%), Hispanic/Latino/a (1.5%).

Participants also responded regarding the setting in which they primarily conduct psychological assessments with children and/or adolescents. The majority of the sample indicated practicing in Independent/Private Practice (46.8%), closely followed by Medical Center/Hospital (38.1%). The remaining respondents indicated practicing in the School System (5.8%), Child/Adolescent Psychiatric or Pediatric Clinic (5.0%), Other (2.9%), and Community Mental Health Center (1.4%). Additionally, respondents were asked to indicate the purpose(s) for which they conduct psychological assessments with children and/or adolescents. For this item, respondents were able to select all options that applied to them; results are depicted in Table 2. Of the eleven respondents who selected *other*, responses ranged in specificity, including references to treatment planning, identification of strengths, social security assessments, obtaining baseline functioning, and monitoring cognitive changes. Further, respondents were asked their level of familiarity with collaborative and therapeutic assessment practices using a 5-point Likert scale. Responses were highly mixed, with 25.9% indicating that they are *moderately* familiar, 24.5% *somewhat*, 18.5% *slightly*, 17.0% *extremely*, and 14.1% *not at all*.

Instrumentation

To gather quantitative data to inform the field of psychological assessment—particularly in the domain of child and adolescent feedback—and to address the research questions, a 31-item survey was developed (see Appendix A). This survey instrument was developed for this study given that no existing measure examines this specific construct. Still, the nature of the items was largely driven by the existing scholarship on assessment feedback practices, C/TA, TA–C/A, and current ethical standards. Above all, this survey was modeled on an instrument developed and utilized by Curry (2004). In that survey, Curry asked 32 items, which together measured

respondents' uses of psychological assessment, clientele, assessment instruments, select TA practices, feedback practices, and training in test feedback. Modifications to that study were made to address this study's focus on child and adolescent assessment and feedback, as well as more directly examine both the barriers and perceived benefits of providing feedback. The following literature was also prominently consulted during item development: APA (2010, 2012); Curry and Hanson (2010); Finn (2007); Finn & Tonsager (1997); Finn et al. (2012); Gorske (2008); Nardi (2003); Peterson (1998); Schonlau, Fricker, & Elliott (2002); Smith et al. (2007); Tharinger, Finn, & Wilkinson et al. (2008). Additionally, survey items were revised following input from colleagues during the pilot period.

In this survey, the first question served as a screening item to identify psychologists who do not conduct psychological assessments with children and/or adolescents. Participants were asked to respond to this question using a Yes/No format; those that select No (i.e., indicating that they do not conduct assessments with children and/or adolescents) were diverted via the Qualtrics online software and were not able to complete subsequent items. This screening question was considered important given that past research has indicated that not all psychologists conduct assessments (Curry & Hanson, 2010; Norcross & Karpiak, 2012) and, further, certainly not all assessors work with children and/or adolescents. Following the screening question, the survey items were intended to gather information in the following areas: (a) respondent practice setting; (b) purpose(s) of assessment; (c) feedback practices, pertaining to both child and adolescent assesseees and parents; (d) reasons for sharing feedback; (e) barriers to sharing feedback; (f) how the purpose of the assessment affects feedback; (g) training in client-directed feedback delivery; (h) familiarity and utilization of C/TA practices; (i) respondent perceptions of feedback; and (j) respondent demographics.

With respect to feedback practices, the survey investigated how often and by which methods psychologists share test results with assessees of varied age groups. It also asked respondents to provide reasons for why they share and/or withhold feedback from assessees of varied age groups. For example, the survey presented the following as potential reasons for not providing feedback: (a) the client was unable to understand assessment findings; (b) the examiner was unprepared to communicate feedback effectively; (c) challenges (e.g., anxiety, discomfort) related to providing negative assessment findings; (d) sense that feedback could cause harm; (e) client refusal to participate; (f) time constraints; (g) issues of financial reimbursement for feedback; and (h) other (please specify). Also, the survey instrument was designed to utilize automatic skip patterns in that specific questions were shown conditionally, based on previous information from each respondent. For example, if a participant indicated that they provide parents/caregivers feedback *every time*, then the later question *On the occasions when you do not provide feedback to parents/caregivers, please indicate your reason(s)* would not be displayed. Likewise, if a participant indicated that they *never* provide feedback to children, then the question *Please indicate your reason(s) for providing children (ages ≤ 11) with feedback?* would not be displayed. This was done to minimize errors and streamline the respondent's process (Schonlau et al., 2002).

Additionally, participants were asked to respond in an open-ended format to factors that may increase their motivation and/or ability to provide assessment feedback. This was one of three open-ended response items on the survey, though some of the multiple-choice questions included an *other* with text entry option. In general, the use of open-ended questions in surveys facilitates the collection of rich, descriptive, and unexpected information from the relevant population. It can also help peak or guide later investigation. This was demonstrated, for

example, in Peterson's (1998) dissertation research, in which the open-ended item revealed themes relevant to the current study. Specifically, several respondents from that study commented on the process of child/adolescent feedback, with one writing: "It is a cop-out not to give feedback to children, adolescents, impaired or difficult patients. With children and adolescents one must present feedback in a language they can understand" (p. 78).

The use of open-ended items was considered essential to the present study given the novelty of this topic area. The format provided the opportunity for each respondent to offer their expertise in their own words. The second open-ended survey item presented to respondents solicited thoughts on how the purpose of the assessment affects the feedback process. During the instrument development and piloting stages, several colleagues commented about how the purpose of the assessment (e.g., educational, neuropsychological) or referral question might influence feedback. It was determined that this should be approached using an open-ended format to best employ the knowledge of the respondents. Of note, the open-ended items were limited in number for efficiency purposes and dispersed throughout the survey.

With respect to training in client-directed feedback delivery, this survey inquired about the extent of past training, perceived helpfulness of various training experiences (i.e., doctoral coursework, practica/externship, pre-doctoral internship, and postgraduate training) in learning how to provide feedback, and interest in receiving additional training in this area. With respect to respondent perception, questions were intended to investigate practitioners' attitudes toward various aspects of client-directed feedback, such as its appropriateness and effects. Practitioners were also asked to respond on the topic of ethical responsibility to provide clients with assessment feedback. With respect to C/TA activities, the survey asked respondents, much like in

Curry (2004), about their familiarity with and utilization of practices consistent with collaborative and therapeutic approaches to testing.

In terms of demographics, respondents were asked to identify their gender and racial/ethnic background. Questions on degree type, year degree attained, and field of degree were also included. For analysis purposes, year of graduation was divided into intervals and coded by decade (e.g., 1980–1989). The survey concluded with an open-ended comments/concerns item. This was intended to provide respondents a final opportunity to share their opinions and experiences in the domain of child-directed feedback. This last open-ended question also provided an opportunity for respondents to share any concerns they may have with the survey (e.g., ambiguous language).

Of note, the survey included a wide variety of response formats, including both structured and unstructured types. Regarding the structured response survey items, many were single option variable and on a 5-point Likert scale, while others were multi-option variable and further included an opportunity for the respondent to select *other* and fill-in their own response. Matrix questions were also used in an effort to reduce survey completion time. With the exception of the initial screening item, forced-choice items were not used. This was decided given literature suggesting that forced response items can cause annoyance and dishonest answers (Schonlau et al., 2002). Please refer to Appendix A for more detail on the survey items.

Data Collection

As stated above, the survey used in this study was available to the respondents via the Internet. This was decided for several reasons, including that online methodologies can (a) result in higher response rates, (b) reduce data-entry errors, (c) enhance efficiency, (d) allow for automatization, and (e) increase sample size (Gosling, Vazire, Srivastava, & John, 2004; Kraut et

al., 2004; Nardi, 2003; Schonlau et al., 2002). Also, web-based survey distribution is often more cost-effective than mail distribution. Additionally, increasing research suggests that the use of the Internet to distribute questionnaires does not compromise data quality. For example, results of a large comparative analysis by Gosling et al. (2004) suggested that data collected via web-based methods are typically consistent with that collected via more traditional, paper-and-pencil methods. The authors also used empirical evidence to evaluate common preconceptions about web-based data collection; they summarized that web-based samples are diverse and motivated, and that findings obtained are generalizable and consistent with other methods. However, they also found that web-based questionnaires can be compromised by participant anonymity. Anonymity can, for example, allow respondents to take a questionnaire repeatedly. Rudestam and Newton (2015) note how this methodological issue is more likely when participation is incentivized. Given that the present study offered random monetary rewards for survey completion, methods to reduce the chance of multiple submissions were enacted. Specifically, the research survey was published on Qualtrics, which is a web-based software tool for creating and conducting survey research. This was deemed the optimal survey tool due to its strict security requirements, quality control settings (e.g., the program prevents multiple contributions from one participant), export features, strong customer support, mobile optimization, and established reputation within academic research.

Procedures. Prior to participant recruitment, a pilot of the online survey was conducted to assess clarity of instructions and survey flow, as well as to identify any potential formatting errors or item ambiguity. The pilot also helped to determine the approximate completion time. During the pilot phase, colleagues were asked to read the recruitment letter, use the provided link to complete the online version of the survey, and offer recommendations. Revisions to the survey

were made based on the feedback provided. This pilot also allowed for confirmation that the data set downloaded correctly from Qualtrics. Additionally, all automated skip patterns were tested to ensure that they were correctly set. As recommended by Nardi (2003), this was done by taking the pilot survey numerous times each with different responses.

As noted above, participants were recruited from the ABPP online membership directory, the Community for Psychologists in Independent Practice (Division 42 of the APA) listserv, the NPSYCH listserv, and the Division of School Psychology (Division 16 of the APA) Facebook group. Consequently, some of the respondents received emails directly from the investigator to their inbox while others were invited to participate in the study via a listserv or online post. Regardless, each respondent was presented with an introductory recruitment letter (see Appendices B and C) that included a brief description of the study, instructions on how to consent to the research, and a link to the online, anonymous survey. Once respondents clicked the provided link, they were brought to the informed consent page. Respondents needed to confirm that they had read and agreed to the consent statement by clicking a radio button before beginning the survey (see Appendix C for the Informed Consent). Data collection began on January 14, 2019 and concluded on February 7, 2019.

To maintain anonymity, survey participants were not required to provide identifying information. Also, the online survey did not record IP addresses. For those respondents who chose to participate in the random drawing for a \$100 gift card, their contact information (i.e., email) was kept strictly confidential and was not linked to their survey responses. This was accomplished by creating two surveys on Qualtrics: The “real” survey and an “incentives” survey that populated after completion of the actual survey. Also, to reduce the chance of multiple submissions from the same respondent, the survey utilized Qualtrics’ “Prevent Ballot

Box Stuffing” option. This works by placing a cookie on the respondent’s web browser thereby preventing further submissions from the same computer. At the completion of data collection, participant emails were numbered in the order received. Then, a random drawing was conducted and the gift certificate was emailed to the winner. After this drawing was complete and the gift card sent, all contact information was destroyed.

Data Analysis

To run primary data analyses and examine the research questions and hypotheses, data collected from the survey was downloaded from the Qualtrics website into an SPSS file. This prevented data-entry errors. Data were then analyzed descriptively and inferentially. An alpha value of 0.05 was used for all relevant analyses. Regarding the open-ended items, responses were organized into a small set of meaningful categories. Relevant categories were created after survey collection was complete and responses were read and reviewed. All results are described in the next section.

Results

A total of 139 surveys were considered usable after exclusion criteria was applied. As described above, the survey was designed to allow items to be skipped at the discretion of the respondent. Some items were also automatically skipped as a function of earlier response choices. Consequently, sample sizes vary across analyses. This section is organized by hypotheses, research questions, and followed by data obtained from the open-ended survey items. Specifically, three hypotheses were tested using both descriptive and inferential analyses. Seven research questions were then addressed.

Hypothesis Testing

Parties that regularly receive test results. To look at the first part of the first hypothesis—that most respondents will report regularly sharing test results with clients—a

descriptive analysis was conducted on the following survey item: *When conducting psychological assessments with children and adolescents, with whom do you regularly share testing results? (select all that apply)*. Table 3 shows the responses to this question. In particular, 97.8% of respondents reported regularly sharing results with the parents of assessed minors. The hypothesis is thus supported. Of note, only two of the respondents indicated that they share results with *no one*. The second part of the first hypothesis—that respondents will report sharing test results more often to adult parents compared to assessed minors—was also supported by the data.

Extent of feedback provision and client age. The second hypothesis—that inclusion in feedback sessions will vary by assessee age—was tested by conducting the Friedman test. The survey question of interest asked: *When working with children and adolescents, please indicate how often you provide verbal assessment feedback directly to the following*. In this analysis, the extent to which respondents provide verbal feedback (i.e., Never, Rarely, Sometimes, Usually, or Every time) served as the dependent variable and assessee age group as the independent variable. The variables in this analysis are ordinal, and the nature of the data was repeated measure under different age groups (i.e., children ages 8 and younger versus children ages 9–11 versus adolescents ages 12–14 versus adolescents ages 15–17). Of note, the Friedman test is used to test for differences between groups when the dependent variable being measured is ordinal. It was used as an alternative to the one-way ANOVA with repeated measures given that the data assumption of normality was violated. Results of this analysis indicated that the frequency of feedback provision was significantly different across the age groups of minors, $X^2(3) = 304.30, p < .001$ (Table 4). Specifically, the youngest age group (i.e., children ages 8 and younger) had the lowest mean rank, meaning that they have the lowest frequency of receiving verbal assessment

feedback. In contrast, mean rank comparisons show that the oldest age group (i.e., adolescents ages 15–17) were the most likely to receive feedback. Based on these results, the second hypothesis stands: Inclusion in feedback sessions varies by assessee age.

Extent of feedback provision and C/TA practices. To test the third hypothesis, that utilization of C/TA practices (i.e., survey question #23) will be positively correlated with current feedback provision to both children and adolescents (i.e., survey question #7), Spearman's correlation coefficient tests were conducted. Of note, Spearman's correlation was run on all four age groups (as labeled above). This test was used as an alternative to the Pearson product moment correlation, and similarly measures the strength and direction of association between two variables. Results indicated a significant positive correlation between utilization of C/TA practices and frequency of feedback provision to children ages 8 and younger, $r_s(126) = 0.25, p < .001$; children ages 9–11, $r_s(126) = 0.22, p = .01$; adolescents ages 12–14, $r_s(128) = 0.20, p = .02$; and adolescents ages 15–17, $r_s(129) = 0.17, p = .05$. That is, the higher respondents ranked their use of C/TA, the higher they ranked their likelihood to provide feedback and vice versa. This hypothesis was thus supported by the data.

Research Questions

Frequency of feedback provision to parents/caregivers. With regard to the first research question, which addressed how often psychologists provide verbal assessment feedback to the parent(s)/caregiver(s) of child and adolescents assessees, results suggested that a majority of the respondents, 81.3%, do so “every time.” Only 1.4% of respondents reported *never* or *rarely* sharing feedback with parents/caregivers. Relatedly, 86.3% of respondents indicated that they always provide a written summary or report to parents/caregivers. Table 5 shows the participants' responses to these items.

Frequency of feedback provision to children and adolescents. Table 6 provides a summary of how participants responded to delivering verbal feedback directly to assessed minors of varying age groups. For example, a review of these frequency measures suggests that for children ages 8 and younger, a majority of participants responded that they never (21.6%) or rarely (43.9%) provide assessment feedback to said grouping. For children ages 9–11, a majority rarely (28.1%) or sometimes (41.7%) provide feedback; for adolescents ages 12–14, a majority sometimes (36%) or usually (36%) provide feedback; and for adolescents ages 15–17, a majority usually (51.8%) or always (25.9%) provide feedback.

Factors associated with feedback provision. The third research question aimed to explore what factors, if any, are associated with the frequency of feedback provision to assessees. Several factors, including sample characteristics and respondent perspectives, were checked for their association with feedback provision using a variety of statistical tests, as described in the following sections.

Feedback provision and graduation year. Spearman's correlation coefficient test was conducted in an examination of the association between the frequency of feedback provision to children and adolescents and years since graduation. For the purpose of this analysis, graduation years were divided into different group categories and coded as follows: 1970–1979 as 1, 1980–1989 as 2, 1990–1999 as 3, 2000–2009 as 4, and 2010 and onward as 5. Results were only significant for one age group (Table 7). Specifically, the Spearman's correlation test found a significant negative correlation between provision of feedback to adolescents ages 15–17 and respondent graduation year, $r_s(131) = -0.21, p = .02$. This indicates that psychologists who graduated more recently have a lower frequency of providing assessment feedback to older adolescents.

Feedback provision and field of degree. The Kruskal-Wallis test was used to examine a potential association between the frequency of feedback provision and respondents' field of degree (i.e., Clinical Psychology; Counseling Psychology; School Psychology; Neuropsychology, or Other). Of note, the Kruskal-Wallis test was used as an alternative to the one-way ANOVA given that the data assumption of normality was violated. Results showed that psychologists' field of degree was not significantly related to the provision of feedback to parents/caregivers ($X^2(4) = 5.38, p = .25$), children ages 8 and younger ($X^2(4) = 1.96, p = .74$), children ages 9–11 ($X^2(4) = 0.76, p = .94$), adolescents ages 12–14 ($X^2(4) = 0.91, p = .92$), or adolescents ages 15–17 ($X^2(4) = 4.38, p = .36$).

Feedback provision and practice setting. The Kruskal-Wallis test was also used to look for association between the frequency of feedback provision and respondents' primary practice setting (i.e., Child/Psychiatric/Pediatric Clinic, Community Mental Health Center, Independent/Private Practice, Medical Center or Hospital, School System, or Other). Similar to the results of the above analysis, no significant relationship was found between psychologists' practice setting and frequency of feedback provision.

Feedback provision and gender. To investigate whether respondents that differ in gender provide feedback to different extents, the Mann-Whitney U test was conducted. This is a non-parametric test which is preferred when the independent variable involves only two groups. Results indicated that frequency of feedback provision to children ages 8 and younger ($U(4) = 1157.50, p = .02$), children ages 9–11 ($U(4) = 1182, p = .04$), adolescents ages 12–14 ($U(4) = 1136.50, p = .01$), and to adolescents ages 15–17 ($U(4) = 1157, p = .01$) was significantly related with the gender of the respondents. A review of mean rank comparisons showed that male psychologists provide feedback more frequently to children and adolescents. Of note, there was

no significant relationship found between respondent gender and frequency of provision of feedback to parents/caregivers ($U(4) = 1447$ $p = .37$).

Feedback provision and perspective on ethical responsibility. Spearman's correlation was computed to examine whether psychologists' perspective on ethical responsibility to share findings with child and adolescent assesseees was related to the frequency with which they provide feedback to these groups. Results indicated a significant positive correlation across all age groups analyzed (Table 8). For example, results showed that a sense of ethical responsibility to provide feedback to children (ages <11) was positively correlated with provision of assessment feedback to children ages 8 and younger ($r_s(130) = .49$, $p < .001$) and children ages 9–11 ($r_s(130) = .44$, $p < .001$).

Feedback provision and perspective on feedback being beneficial. Further, Spearman's correlation tests were conducted to examine whether psychologists' perspective on feedback being beneficial to child and adolescent assesseees was related to the frequency with which they provide feedback to these groups. Results again indicated significant positive correlations across all age groups analyzed (Table 9).

Feedback provision and perspective on feedback causing harm. Similar to the above analyses, Spearman's correlation tests were conducted to examine whether psychologists' perspective on feedback causing harm to children and adolescents was related to the frequency with which they provide feedback. This test resulted in significant negative correlations across all age groups analyzed except with respect to adolescents ages 15–17 (Table 10). That is, no significant relationship was found between the extent to which psychologists provide feedback to older adolescents and their perspective on feedback causing harm.

Reasons for providing feedback. Participating psychologists were asked to select reasons why they provide children (ages ≤ 11), adolescents (ages 12–17), and parents/caregivers with verbal assessment feedback. The various responses and their corresponding frequencies are depicted in Table 11. For example, 88.5% ($n = 123$) of respondents indicated that they provide feedback to parents/caregivers because of an ethical responsibility, while only 14.4% ($n = 20$) indicated this for child assesseees. Respondents were also provided the opportunity to select *other* and fill in their responses. These included references to using feedback to (a) build rapport, (b) validate difficulties, (c) reinforce strengths, (d) bolster adherence to treatment recommendations, and (e) honor the time commitment children and adolescents put into an evaluation.

Barriers to providing feedback. In order to examine the reasons psychologists name for withholding or not being able to provide feedback to particular age groups, respondents were asked to indicate the relative barriers to providing feedback to children (ages ≤ 11), adolescents (ages 12–17), and parents/caregivers. Participant responses and corresponding frequencies are depicted in Table 12. For example, the top three reasons for withholding assessment feedback from child assesseees were: (a) *Child was unable to understand assessment findings* ($n = 110$, or 79.1%); (b) *Specific challenges (e.g., anxiety, discomfort) related to providing negative findings* ($n = 36$, or 25.9%); and (c) *I thought feedback could cause harm to the child* ($n = 34$, or 24.5%). Relatedly, the top three reasons for withholding feedback from adolescents were: (a) *Adolescent was unable to understand assessment findings* ($n = 83$, or 59.7%); (b) *Adolescent refused to participate* ($n = 47$, or 33.8%); and (c) *I thought feedback could cause harm to the adolescent* ($n = 30$, or 21.6%). Lastly, the top three reasons for withholding feedback from parents/caregivers were: (a) *Other* ($n = 17$, or 12.2%); (b) *Parent/caregiver refused to participate* ($n = 13$, or 9.4%); and (c) *Time constraints* ($n = 6$, or 4.3%). Of note, the frequency numbers for the

parent/caregiver group are much less than those for children/adolescents given aforementioned automatic skip patterns.

Those who selected *other* indicated issues related to scheduling and no shows (versus outright refusal), early discharge from the setting in which the assessment took place, legal reasons (e.g., “legal case if hired by defense rather than plaintiff”), research purposes, adolescent indifference, and parent preference/unwillingness for their child to hear results. Also, several responses indicated that the parent—rather than the assessor—is tasked with communicating the findings to the child. Additionally, one respondent wrote that they never provide feedback to children, concluding: “frankly, never considered it.”

Feedback training. In order to examine respondents’ past training in client-directed assessment feedback, they were asked to rank their level of agreement to the following two statements on a 5-point Likert scale: (a) *I received sufficient supervised training in the delivery of assessment feedback to children and adolescents*, and (b) *I received sufficient supervised training in the delivery of assessment feedback to adults*. Frequency measures were examined (Table 13). For example, a majority of the respondents indicated that they either somewhat ($n = 42$, or 30.2%) or strongly ($n = 47$, or 33.8%) agree that their training in the delivery of assessment feedback to minors was sufficient. Relatedly, a majority of the respondents indicated some ($n = 27$, or 19.4%) or strong agreement ($n = 69$, or 49.6%) that they received sufficient training in the delivery of assessment feedback to adults.

Feedback provision and sufficiency with past training. To better understand the relationship between current feedback provision and respondents’ ratings of their past training in feedback to adults and (separately) to children and adolescents, Spearman’s correlation coefficient tests were conducted. When looking at past training in delivering feedback to children

and adolescents, no significant relationships were found (Table 14). On the contrary, when looking at past training in feedback to adults, results found a significant positive correlation between the extent to which psychologists provide feedback to parents/caregivers and sufficiency with past training, $r_s(134) = 0.23, p = .01$. This indicates a higher frequency of providing assessment feedback to parents/caregivers if the psychologists report having more sufficient training in providing feedback to adults.

Lastly, two survey questions not addressed above still garnered purposeful data. First, respondents were asked to rate the helpfulness of various educational and training experiences. Second, they were asked to indicate their level of interest in receiving additional training in the delivery of assessment feedback to children and adolescents. Sample descriptives are depicted in Tables 15 and 16, respectively.

Open-Ended Survey Items

Factors to increase the practice of feedback provision. First, respondents were asked what might increase their ability and/or motivation to provide assessment feedback. Sixty-six participants provided a response to this item, though approximately 20 expressed that they always provide feedback and/or that *nothing* was needed to increase their provision of feedback. Of the remaining responses, the following broad themes were revealed: (a) training and availability of pertinent resources, (b) issues around payment and time, and (c) parent involvement and collaboration. These themes, including selected quotations, are reviewed below. Additionally, a few selected responses that do not fit these themes are briefly addressed.

Several participants commented on the need for further training in this area. For example, one wrote, “I wish I had had more specific instruction and modeling in providing feedback to children in my training. The focus was on parent feedback (which is important), but we did not

regularly have feedback sessions for children.” Another wrote, “I enjoy doing feedbacks already. I think specific training to give feedback would be helpful in graduate programs rather than just administration, scoring, and report writing.” One participant specifically requested seminars in therapeutic assessment. Relatedly, several mentioned a need for more literature and resources pertaining to feedback provision (e.g., “case study examples;” “having better tools to explain finding in an age appropriate manner;” “user friendly language and template that is age/developmentally appropriate”).

Issues of time, payment, and reimbursement were also frequently referenced. Many respondents simply stated the need for “additional time” and “to bill,” while others went into detail regarding reimbursement. For instance, one participant wrote: “Better insurance reimbursement would always help. The new testing codes leave a lot to be desired in terms of payment certainty.” Relatedly, one expressed the need for “more clear cut financial reimbursement (not just embedded into Professional Services code).” Another respondent provided even more detail: “Sure, reimbursement would be great though I have had success billing therapy units for this (90834/90837).”

The third theme involved the role of parents in the assessments of children, and how this influences feedback. For example, several participants commented as to the parents’ willingness (or unwillingness) for their child to receive feedback. Others discussed the need for parents to be encouraging, including one respondent who clarified:

- (1) If parents advocated for their children to be involved... but that would usually require
- (2) that they’re taken out of school for a feedback session. I always discuss with the parents how they can explain the results in an age-appropriate manner.

Another respondent noted a different approach: “I like to have parents and children together to discuss the results of an evaluation and believe that I can do this in a way that both the child and parents can understand.” Yet another mentioned how providing children with feedback can help both the child and their parents, and “in turn, our assessments can lead to a more impactful change in their lives.”

In terms of responses not covered by the above themes, several individuals appeared to use the first open-ended item as an opportunity to discuss their motivation to provide feedback and thoughts on its impact. For example, one participant stated, “I’m already totally bought-in to the process. In my mind, if you do not do feedback, you have potentially lost the majory [*sic*] catalyst [*sic*] for change, increased understanding, and positive outcomes.” Relatedly, one respondent wrote, “I believe that providing feedback in a positive way is an intervention in and of itself.” Another respondent took this opportunity to dispute the thought that feedback provision may be tied to assessor qualities: “The decision to provide assessment feedback to the patient is determined by the developmental age and understanding of the patient and not my motivation or ability.” Others addressed how referral issues (i.e., “better network of providers to refer for additional services”) and provider collaboration (i.e., “increased participation/collaboration with the inpatient treatment team”) impact feedback provision. Of note, only one respondent specifically addressed a situation in which feedback cannot be provided: “I have a federal contract to provide assessments that does NOT include feedback which is not permitted.”

Purpose of assessment and feedback. The second open-ended survey item solicited thoughts on how the purpose of the assessment and/or referral question may affect the feedback process. Sixty-six participants provided a response to this item. The majority of responses

acknowledged that the purpose of the assessment and/or referral questions does in fact influence feedback, but did not elaborate on *how*. Others acknowledged that the referral question guides feedback but that psychologists must relay other findings as well. Of the remaining responses, themes included the following: (a) “the client” and setting, (b) assessment findings, (c) assessee-related factors, (d) type of assessment sought, and (e) therapeutic value of feedback.

As one respondent summarized, “who the ‘client’ is impacts the entire evaluation, including feedback.” Several respondents acknowledged that feedback, like most aspects of testing, hinges on who is the designated client. For instance, one respondent simplified that “if the client did not seek eval, may be reluctant to hear fb.” Others referenced how the setting impacts the process. For example, one respondent distinguished between two familiar work settings: “In education when I was a chief psychologist it was 100% important for feedback and follow up! Now working for [sic] social security in assessments I am not permitted to provide feedback or details.” Another reported that her “patients are referred by the state or school who then takes responsibility for how the results are conveyed.”

Other responses specifically addressed how the setting may *limit* feedback provision. For instance, it was reported that feedback from school-based assessments are often provided during IEP meetings. One respondent indicated that that the “DOE really serves as the client over the student” and that “feedback is often provided exclusively during the IEP meeting, which includes several professionals and often does not provide real opportunity for delving into the results.” Similar issues were brought up, but for inpatient settings. For example, one respondent provided the following illustration:

The inpatient environment affects tremendously given that our client is the treatment team, not the client themselves. This also impacts the report component—it only gets sent to the family if they request it from medical records, and can only be sent after discharge.

Several respondents described how the assessment *findings* impact feedback, particularly with regard to relaying surprising and/or sensitive information, or a poor prognosis. For instance, one respondent acknowledged, “the more complex or the more ‘sensitive’ the information obtained, the more difficult it is to communicate it to young children.” A respondent who indicated that they work in a hospital setting noted that “children who have complex medical histories and who may have lost skills (e.g., TBI) often require feedback assisting them in understanding their new circumstances and the realities of long term care or intervention.”

Another focused on concerns regarding causing harm:

I have had a few isolated cases where feedback had the potential for doing harm. The issue is both the timing and the content. Working with psychiatrically unstable kids can lead to negative consequences if the provider is not careful about what they are saying and when.

While some focused on how the assessment findings may direct feedback, others emphasized the impact of client factors on the process. Such responses included issues related to patient competence, cognitive functioning (e.g., with one saying that those with impaired functioning “will rarely benefit from direct feedback”), diagnosis (e.g., “severe autism”), and the age of assessee. One respondent explained: “The age and cognitive and personality issues at play affect the feedback process and inform how I approach the feedback. For example, the words used and the explanations given.” Similarly, a respondent specified that patient characteristics guide how “directly/confrontationally I present” the results versus “how carefully and

supportively I support.” One respondent generalized that the “lay audience may have trouble understanding [feedback].” Another included several of the above factors, saying:

For me, I think DIAGNOSIS affects the feedback process with children the most. Specifically, when I diagnose intellectual disability, I was to be very clear and explicit with parents about what that means, while also allowing them the space to have an honest reaction and ask their questions. In these situations, I prefer to meet with the parents first and then bring the child/adolescent in for a briefer discussion that focuses on strengths and areas of difficulty rather than diagnosis.

Unlike the above respondent, some who specifically touched on the age of the assessee indicated that the parents/caregivers are the recipients of feedback, not the children.

Another category of responses addressed the type of assessment sought, and how this impacts the feedback process. Some indicated that the purpose and/or referral question can narrow the results provided. Others were more specific; for example:

Educational purposes—feedback is supposed to focus on educational impact and classification/eligibility, rather than diagnosis, for intervention planning;
neuropsychological and personality purposes—feedback is likely focused on diagnosis and intervention planning.

Similarly, a respondent who specified that their assessment work is psychoeducational and done in private practice reported that feedback typically focuses on “cognitive / attention / achievement processing [results] and how the child’s particular strengths and weaknesses affect him/her in school.” A private practitioner who completes neuropsychological evaluations indicated that “much of the data is for the referring provider.”

Additionally, a few respondents specifically referenced the TA approach. Interestingly, one person differentiated their TAs from other referrals, saying:

Although I always integrate collaborative interventions and emphasize feedback, the process is certainly different with my TA referrals. The discussion section is often 2 hours and spread over two days to allow time for them to digest information and come back.

Lastly, several respondents discussed their thoughts on how feedback—no matter the purpose or referral question—can be therapeutic. In some responses, the mechanism was described. For example, one respondent wrote, “An assessment itself [*sic*] can have enormous therapeutic [*sic*] value. the feedback session is an integral part of this, facilitating reframing and then narrative co-construction of the child/family’s understanding of the child’s condition and needs.” Another voiced the perspective that feedback “initiates patient awareness and leads to insight, which leads to positive change.” The value of assessment, from the outset of testing, was further illustrated by the following response:

I think that it is a complex process of planned co-incidence whereby trained professionals can use evidence-based assessments and clinical information about their patients to help activate the assessment process through a combination of therapeutic approaches. It is the critical piece for me as a clinician. It helps improve outcomes, compliance with recommendations, and buy-in by those involved. It helps elevate the static documentation of a report to a vibrant and shared experience where positive change can occur.

Comments on child-directed feedback. In the final survey item, respondents were invited to include narrative comments or experiences regarding child-directed feedback provision. Twenty-eight participants provided a response to this item. Several respondents

indicated interest in the topic area, and excitement about the research under investigation. One especially eager respondent wrote, “I am so excited to see that you are pursuing this!!!! Over the past few years I’ve developed an entire model for giving feedback to children themselves.” A review of the remaining comments revealed several themes, as discussed below.

A number of respondents described their own experiences with assessment feedback to minors. For some, this included an account of how the age of the assessee typically impacts their process. One respondent thoroughly explained:

I provide verbal feedback & report to both parents, if there are 2, and verbal feedback & personal letter to clients aged 16–21, who I don’t feel should see the report. Children aged 7–15 are given verbal feedback with one parent in the room as a ‘fly on the wall,’ so everyone has heard the same thing and is on board with the treatment plan. Children 5–8 are given feedback if it will be helpful. If not, parents are instructed as to what to say to the child.

Another emphasized developmental level over age saying, “the developmental level may be more relevant than the age of child/adolescent when deciding how and when to provide direct feedback to them.” Relatedly, some respondents directly spoke to the parents’ role in decision-making about feedback inclusion. One wrote, “feedback is always available to the child in my practice, but I do give the parent-“client” the choice as to how to use the time (coming alone or bringing the child).”

Others focused on *how* they provide feedback to children. For example, a few respondents discussed the importance of using visuals and alternative mediums with minors (e.g., “I am constantly creating new letters, visual diagrams, or interactive mediums to

communicate the findings [to children].” Two other respondents emphasized strength-based feedback, with one writing:

I give strength-based feedback to my child/adolescent clients. They typically feel defined by their weaknesses and presenting a balanced picture of their many strengths and how some weaknesses impact their ability to function to their potential is helpful to them. For adults I support their strengths but also give realistic results of findings as I believe it helps them plan their future more realistically. for example, I gave feedback this week to a medical school candidate who wanted to be a surgeon but he had poor visual spatial skills, and made poor decisions when under pressure. I beileve [*sic*] that was helpful to him in thinking about other specialties that he may be more suited for.

A few respondents emphasized the need to develop their own approach given insufficient training, guidance, and/or existing models. For example, one wrote:

I developed my own approach to feedback when there were no validated, measured approaches available and then subsequently used it over a 13-year career as a professor in higher education. It is an essential part of training that is highly overlooked because research and techniques have not been effectively elaborated and published.

Another stated that they learned to relay “only the main findings (maximum of 3) and their related “action points” (e.g., recommendations) as to not overwhelm the family and ensure they walked out with a good understanding of the general findings.”

Another category of responses addressed the importance of providing feedback that is informed, sensitive and/or interactive. One respondent addressed concerns of causing harm, writing:

While I feel feedback in general is a positive and necessary part of the assessment process, it could potentially do harm if the individual providing feedback is unaware or ill-trained to handle the potential reactions of those to which feedback is being provided. That is what makes it more difficult when providing feedback to both parent and younger children simultaneously [*sic*], due to increased time needed (depending on the results and question being answered) to address child's concerns, correct any misinterpretations regarding what the information [*sic*] means to them/about them, etc.

Similar issues were illustrated in the following response:

Regarding the harm/benefit questions, this depends on the evaluator and how the feedback is provided. Sure, it can cause harm to a child or adolescent if not given in a developmentally thoughtful way, but this is also true for how feedback is offered to parents or adult clients more generally.

Another set of responses provided recommendations for further reading. Specifically, four respondents mentioned "Therapeutic Assessment" or Stephen Finn explicitly. Three referenced the book *Feedback that Sticks* (e.g., "The book *Feedback that Sticks* has been instrumental to me in terms of providing all different types of feedback. I highly recommend to all my trainees and colleagues [*sic*]").

Lastly, respondents used the final open-ended item to report concerns with the survey itself. Two participants remarked on the "field of degree" survey item: One asking for the inclusion of "board certification in neuropsychology as a variable" and the other stating that "the question about the field of degree is not specific enough." Also, a few respondents referenced finding the phrasing of "collaborative and therapeutic" in survey questions 22 and 23 ambiguous, or not adequately defined. One person said "When you refer to 'collaborative and therapeutic'

assessment feedback, I was unsure if that was a particular model. If so, I am not familiar with the specific model. However, I practice collaboratively and believe that assessment is as much therapeutic as it is diagnostic.”

Discussion

This study sought to explore the feedback practices of psychologists who conduct assessments with children and/or adolescents. Previous research has spoken to the therapeutic benefit of client-directed feedback, while also indicating that it is an underemphasized practice. Thus, this survey sought responses on the frequency of feedback provision, and also garnered insight into the factors that influence this process. The results provided several findings that warrant further attention. Implications and direction for future research are also discussed.

Parties that Regularly Receive Test Results

In light of the established APA (1992, 2002, 2010) mandates to inform clients of assessment results and past empirical research in this area, the finding that the vast majority of respondents (i.e., 97.8%) *regularly* share test results with their clients was anticipated. For comparison, Peterson (1998) found that 89% of practitioners *regularly* share results orally or in writing (66% orally); Smith et al. (2007) found that 71.3% provide in-person feedback at least *usually*; and Curry and Hanson (2010) found that 65.6% provide verbal feedback *usually* or *every time*. Though each of these studies used slightly different criteria to assess frequency of feedback provision, results from the present research appear to constitute the greatest likelihood of practitioners sharing results with their clients. Given that it is also the most recent study, results likely reflect the paradigm shift from viewing feedback as pro-forma to essential and beneficial.

Unlike the previous studies that examined feedback practices more generally, this survey focused on feedback with child assessees. Child-directed feedback is covered far less in the literature, and it was hypothesized that of the respondents who regularly share test results with their clients, they will report doing so more often with the adult parents/caregivers than the assessed minors. While this finding was supported by the data, a review of frequency data reveals that a majority of respondents do in fact regularly share results with child/adolescent assessees (70.5%). Given so, results from the current study provide further evidence that many psychologists are currently deviating from a more traditional approach in which minors were excluded from the feedback process. Still, even in the cases where feedback is provided only to the parent, benefit is not lost. While the current study is grounded in the perspective that feedback ought to be provided to child assesses in addition to their parents, past research has clearly demonstrated positive outcomes from parent-directed feedback alone (e.g., Gorske & Smith, 2012; Tharinger et al., 2009). The role of parents/caregivers in the assessment of children is essential, as illustrated throughout this section.

Extent of Feedback Provision and Client Age

A main finding of this study was that the extent to which assessors provide verbal assessment feedback depends on the age of the assessee, with younger children receiving significantly less frequent feedback than adolescents. For instance, 18.7% of psychologists reported usually or always providing feedback to older children (aged 9–11) versus 77.7% with older adolescents (aged 15–17). While these results suggest that many psychologists do not solely satisfy the ethical standard to inform clients of test findings by providing parent-directed feedback, it can also be inferred that there is much room for progress. Prior research has suggested that feedback can improve a child's self-understanding and contribute to therapeutic

change (Fischer & Finn, 2008; Tharinger, Finn, & Wilkinson et al., 2008; Tharinger & Pilgrim, 2012). Several of the respondents in the current survey similarly addressed the benefits of child-directed feedback in the open-ended items (e.g., calling it a “catalyst for change” and “an intervention in and of itself”). There are also publications that help guide practitioners on how to provide feedback to children and adolescents (e.g., Becker et al., 2002; Postal & Armstrong, 2013; Tharinger, Finn, & Hersh et al., 2008). As such, greater efforts should be made to include children of all ages in the feedback process. One may even argue that if psychologists have the ability and resources to provide older adolescents with feedback much of the time, then children should similarly be afforded this opportunity provided modifications in approach.

Though several writings have inferred that adolescents are more likely to be included in the feedback process than younger children, the present study appears to be the first time that the relationship between client age and provision of feedback has been directly studied. Findings help to quantify aspects of Peterson’s (1998) research, which examined various factors that contribute to feedback. Specifically, she found that a good portion of survey respondents indicated that the assessee’s age contributed to their decision to *not* provide feedback. Results of that study also indicated a relatively solid consensus regarding the appropriateness of feedback for adults and adolescents but less so for child assessees.

Extent of Feedback Provision and C/TA Practices

The finding that a strong, positive relationship exists between utilization of C/TA methods and frequency of feedback provision is in line with existing literature. Although this relationship has not been directly studied, an abundance of the literature on collaborative and therapeutic approaches to assessment specifically address the importance of client-directed feedback, including with child assessees (e.g., Finn & Tonsager, 1997; Finn et al., 2012; Fischer,

2000; Glasser, 2007). Many of the C/TA authors cited above are helping to revolutionize the perception of personalized feedback as necessary and beneficial to the individual under assessment. As such, it is assuring—albeit expected—that assessors who acknowledge utilizing C/TA practices are in fact enacting what is emphasized in the literature (i.e., providing feedback to assesseees regardless of age).

Providing child-directed feedback, in addition to parent feedback, clearly entails a further challenge on the part of the assessor. One must conceptualize and present the information in a manner that is particularly attuned to the developmental level and the unique needs of children, including their family structure. This clearly takes additional considerations, skills, and time—efforts lauded as worthwhile within the C/TA literature. As cited above, several survey respondents used the open-ended format to note their knowledge and/or use of C/TA practices, with a few specifically referencing Therapeutic Assessment. Many others described perspectives and interventions that are in line with such models but did not directly reference any one theory. For instance, respondents wrote about the importance of client collaboration, reframing of problems, the provision of strength-based feedback, and the use of feedback as an intervention.

Factors Associated with Feedback Provision

When looking at factors that are associated with the frequency of feedback provision to minors, several conclusions are supported by the data. First, a positive association between the extent of feedback provision and perspective on ethical responsibility to share results was revealed across all age groups analyzed (i.e., parents/caregivers, children ages ≤ 11 , and adolescents ages 12–17). As discussed, the APA (2010) has a defined position on the ethical necessity of providing assessment results to clients (i.e., that psychologists must take reasonable steps to explain the results to the “individual or designated representative”), but does not offer

directives on the provision of feedback to child assesseees (p. 13). The practice of sharing results with younger assesseees would likely increase if more psychologists considered it to be an ethical responsibility. Ideally, the APA and like organizations would give greater attention to and ultimately promote the inclusion of children and adolescents in feedback sessions. Still, it is notable that many psychologists do in fact view the provision of feedback to adolescents, and even children, as ethically motivated. One respondent acknowledged so in an open-ended format, saying “not ‘APA’ ethical but my own ethical, moral responsibility.”

The finding that male psychologists provide feedback to child and adolescent assesseees significantly more often than female psychologists was not anticipated—and not easily grounded in the literature. Though gender differences in the practice of assessment more generally are beyond the scope of the current study, future research could investigate this issue directly. Also, it is possible that this result is simply a factor of the lower number of males in the study as a whole.

The lack of a significant difference in feedback provision between practice settings is consistent with Peterson’s (1998) research but still somewhat surprising given that several respondents used the open-ended items to discuss how the setting in which they conduct assessments influences feedback. For instance, respondents spoke to the de-emphasis on parent-focused feedback following school-based evaluations (e.g., at IEP meetings). Others mentioned being unable to provide feedback altogether due to patients prematurely discharging from a hospital setting. Additionally, a few respondents indicated that client-directed feedback is never provided in their forensic and social security cases. Interestingly, forensic work was referenced much more frequently in Curry and Hanson’s (2010) research, perhaps given their emphasis on adult assessment (versus child/adolescent).

For three of the four age groups analyzed, no correlation was found between frequency of feedback provision and respondent graduation year. When looking at the provision of feedback to older adolescents, though, psychologists who obtained their degree earlier were actually more likely to provide feedback to this group. Taken together, these results are surprising given the historical shift toward viewing feedback as important and necessary (Finn & Tonsager, 1992). Perhaps the increased experience of those who graduated earlier offsets temporal trends. Also, as discussed below, graduate training experiences appear to have minimal impact on the provision of feedback and thus it is possible that when one underwent graduate education similarly does not impact the feedback process.

Reasons for Providing Feedback

In an effort to better understand what motivates psychologists to share client-directed feedback, respondents were asked to indicate their reason(s) for providing assessment feedback—to parents/caregivers, to adolescents, and then to children. Regarding parent feedback, most psychologists reported sharing results to elicit positive change, to improve understanding, and given a sense of ethical responsibility. In contrast, far fewer psychologists listed ethical responsibility as a reason to provide feedback to children or adolescents, though the possibility of change and self-understanding were highly rated. Taken together, these findings strongly suggest that psychologists see benefit in providing feedback directly to minors. For instance, that 76.3% of those who responded to the question “Please indicate your reason(s) for providing children (ages ≤ 11) with feedback?” perceive feedback as eliciting positive change in children is fundamental to the research at hand. With this majority, it would be difficult to argue against providing feedback to minors whenever possible. These findings also further challenge the information-gathering model of viewing assessment as distinct from intervention. Results

related to the age of assessee and perspective on ethical responsibility are also notable, as discussed above.

Across all three age groupings, several respondents selected “other” and commented as to why they provide feedback to each of the defined groups (i.e., to parents/caregivers, adolescents, and children). One prominent theme that arose was the importance of providing feedback to children and adolescents given their investment (time, effort, etc.) into the assessment process. Testing can be a puzzling and anxiety-provoking process for assessees of all ages, and hearing selected findings can allow children, as one participant stated, “feel less like a bug under a microscope.” Inclusion in feedback may also improve adherence to feedback recommendations. For instance, a few respondents commented about how feedback can increase child “buy-in,” encourage them to be “participants in their own health care and educational program,” and generally enhance their willingness to engage in subsequent treatment. Thus, if children and adolescents are made aware of what might help them, it may increase follow-through.

Barriers to Providing Feedback

In an effort to better understand what hinders the provision of client-directed feedback, respondents were asked to indicate their reason(s) for withholding assessment feedback—again, this was asked with regard to parents/caregivers, to adolescents, and to children separately. Reasons were highly mixed, both within and across age groups. For children and adolescents, several findings were consistent with those addressed in the first section and suggested by assessors from the TAP (i.e., Hamilton et al., 2009; Tharinger et al., 2007; Tharinger, Finn, & Wilkinson et al., 2008; Tharinger, Finn, & Hersh et al., 2008); that is, the sense that the assessee was unable to understand findings, that feedback could cause harm, and issues around time and scheduling. Interestingly, few respondents selected “no financial reimbursement for feedback” as

a hinderance even though several referenced issues of payment when asked in an open-ended format what factors would help increase their ability/motivation to provide assessment feedback.

While over one third of respondents indicated receiving insufficient or neutral levels of supervised training in child-directed feedback (as discussed below), only a few selected “I felt unprepared to communicate feedback effectively” as a reason for not providing feedback to child or adolescent assessees. This finding begs follow-up: for example, do psychologists learn to provide feedback via self-instruction (as found by Curry and Hanson in 2010) and thus not identify feeling “unprepared” and/or are other issues at hand that prevent psychologists from acknowledging unpreparedness and its potential impact on their practice? The former is concerning in that self-instruction implies a high degree of trial and error (Curry & Hanson, 2010). The latter is also concerning, but speaks more to a general limitation of self-administered surveys, as discussed below.

Although it may be argued that several of the barriers here discussed cannot be disconnected from the psychologist assessor, one survey item was specifically designed to target how the assessor’s own feelings (e.g., anxiety, discomfort) about the test results may influence the act of sharing feedback. Smith and Finn (2014) discussed how the provision of “negative” results can pose particular challenges to assessors. Interestingly, no respondents in the present study indicated that such challenges would impact their provision of feedback to parents/caregivers while many did for child and adolescent assessees ($n = 36$ and 20 , respectively). If assessors refrain from providing feedback out of concern that it is too negative, one would think that this would also deter providing results to parents. Perhaps, though, it would impact the *type* of information shared and not whether feedback occurred at all, given the APA mandate to inform clients of test findings. Nevertheless, and as acknowledged by Tharinger,

Finn, & Hersh et al. (2008), the challenges associated with providing sensitive results should not negate this practice but rather encourage a change in approach—one that reflects a child’s emotional and cognitive capacities.

Responses garnered through the open-ended survey items and “other” options revealed another key factor in the provision of feedback to minors: Parents as gatekeepers. It seems many assessors refrain from sharing feedback to child and adolescent assessees at the request of the parent(s). Some respondents simply stated that it was the parent’s preference, while others indicated receiving outright parent refusal. This barrier to feedback was not emphasized in the relevant literature, and warrants further exploration. Perhaps parents have concerns about how results will be shared with their child. If so, such concerns could be explored and likely alleviated by the assessor (e.g., by acknowledging that results will be brief, strength-based, and tailored to the individual’s needs and abilities). Another possibility is that the parents don’t see the value of child feedback, which would encourage an explanation from the assessor as to the potential benefits (e.g., increasing self-understanding and eliciting positive change). Though, I acknowledge that in order to do so the psychologist would need to be aware of related research.

Similarly, several respondents indicated that parents often prefer to communicate findings to their child versus having the assessor do so. Though likely well-intentioned, this finding is concerning for several reasons. First and foremost, parents are not expected to have the necessary language to present test findings. Sure, they are well-positioned to consider several critical factors such as a child’s emotional capacities, cultural background, and family structure, but it would be unusual for a parent to know how to tailor psychological findings to a child’s developmental level, or to contextualize the results into real-world examples. Also, as Tharinger, Finn, & Hersh et al. (2008) underscored, child assessors should refrain from imparting too much

content or focusing directly on problem areas—points that may befall a parent. In addition, and given the broad theme of time constraints, it seems unlikely that psychologists are routinely supplying such direction and language to the parents of child assessees during their parent feedback session. Further, one must consider the parent-child dynamics; children undergoing assessments often present with various sensitivities that may prevent them from taking in findings conveyed by their parents. As one respondent clarified in an open-ended format: “usually I would allow the parent to communicate the findings, but sometimes the parents are not well equipped or comfortable doing this in a postive [*sic*] way that is helpful for the child.” In all, psychologists are the ones who are ethically responsible for preparing clients for feedback and imparting this information, not the parents. Lastly, there appears to be no research that investigates the provision of feedback to minors by their parents. Perhaps future research can help to tease apart this issue, and provide further clarification on how to best collaborate with the parents during the feedback process.

Another novel finding was that psychologists are far more likely to attribute withholding feedback to client comprehension when concerning children and adolescents versus parents/caregivers. Only 3.6% of respondents selected “the client was unable to understand assessment findings” as a barrier to providing parent feedback, while 79.1% and 59.7% of respondents did so for children and adolescent, respectively. Likewise, a review of open-ended responses revealed several references to feedback being contingent upon a child’s perceived competency or “cognitive ‘bandwidth.’”

Clearly, the provision of feedback to younger assessees is no easy endeavor. The relevant literature highlights the need for assessors to reframe findings in a way that is individualized and sensitive to their current abilities. Although scholarship on methods for sharing feedback with

minors is sparse, it is not absent. As discussed, a literature review provides assurance that there are publications that help guide assessors in providing feedback to children and adolescents, including but not limited to TA-C. In addition, and apart from comprehensive models, several of the authors referenced earlier emphasize the use of plain language, metaphor, visuals, a focus on strengths, and avoiding technical jargon and statistics. Of note, many of the psychologists who responded to the current study provided similar tips.

Feedback Training

To explore prior training in assessment feedback, respondents were asked to evaluate the sufficiency of their training in assessment feedback to adult clients and then to minors. Approximately half (49.6%) of the respondents indicated that they “strongly agree” that their training in the delivery of assessment feedback to adults was sufficient. This increased to just over two-thirds (69%) when including those respondents who “somewhat agree” that their training was sufficient. Though a majority, this finding is still concerning given that it leaves close to one third of psychologists reporting a perception of their training as neutral or insufficient. Delivery of comprehensible feedback is a challenging—but expected—activity of practicing psychologists. Per competency benchmarks, an entry-level practitioner is expected to communicate assessment results “clearly, constructively, and accurately” (Fouad et al., 2009, p. 18). Insufficient training leaves entry-level practitioners ill-equipped to share test findings, which is ultimately to the detriment of clients and their families.

This study, unlike prior surveys, also looked at psychologists’ past training in the delivery of feedback to children and adolescents. About one third (33.8%) of the sample indicated *strong* satisfaction with their training in this area (versus 49.6% for adult-focused feedback), though the percentage neared that for adult training when including those who

“somewhat” agreed that their training was sufficient. This finding is somewhat surprising given literature that specifically speaks to a lack of preparedness to deliver test impressions to children and adolescents (Curry & Hanson, 2010; Rupert et al., 1999; Tharinger, Finn, & Wilkinson et al., 2008). Perhaps, use of the word “sufficient” set a low benchmark. Another possible explanation pertains to the present study’s inclusion criteria (i.e., psychologists who perform assessments with children and/or adolescents). All respondents practice child/adolescent assessment, a specialized field; it is possible that they chose this field following positive training experiences or, given their interest in the area, independently sought related training. This is supported by the aforementioned frequent reference in the open-ended items to therapeutic assessment and specific trainings and literature.

In an effort to better understand past training experiences, and to provide information that could inform education and training in assessment, this survey also inquired as to the helpfulness of past training experiences, including doctoral coursework, practica/externship, internship, and postgraduate training. Results are consistent with previous research in that a large number of psychologists reported receiving insufficient training in feedback while in graduate school (Butcher, 1992; Curry & Hanson, 2010; Rupert et al., 1999). In the current study, just over one-half (53.3%) of the respondents indicated that doctoral coursework was “not at all” or only “slightly” helpful in their learning how to provide feedback. Such gaps in graduate training were similarly found by Curry and Hanson (2010) in their survey of practitioners. One can argue that this leaves students unprepared for internship and even, as Curry and Hanson contended, bears implications for their competitiveness during the application and match process.

Present findings are somewhat more hopeful than previous research when looking specifically at the training received during pre-doctoral internship. For example, 64% of

respondents found the training they received on internship to be “moderately” or “extremely” helpful in their learning how to provide feedback, while only 15.8% found it “slightly” or “not at all” helpful. These results can be compared to Curry and Hanson’s (2010) findings where 33.5% of the surveyed practitioners indicated that their internships were of little or no help at all. Still, the most helpful training—at least with respect to the current study—appears to occur during postgraduate educational experiences. Future research could inquire as to what types of postgraduate experiences are particularly helpful in learning how to provide feedback to children and adolescents.

Lastly, psychologists were asked to quantify their interest in receiving additional training in the delivery of feedback to children and adolescents. The modal response was “moderately” ($n = 41, 29.5\%$), followed by “somewhat” ($n = 35, 25.2\%$). Participants also used the open-ended items to remark on their wish for more specific instruction on feedback during their training, including references to modeling and therapeutic assessment seminars.

Feedback Provision and Sufficiency with Past Training

Interestingly, self-reported sufficiency with past training in child-directed feedback was not correlated to current feedback provision to minors of any age. However, a significant correlation was found between past training in the delivery of feedback to adults and current feedback to parents/caregivers. Contributory factors to these contrasting results are not obvious, though it is possible that the act of providing feedback to children and adolescents—a challenging, nonmandated task—is driven from a unique perspective on its benefit and not necessarily reflective of past experiences. Another possible explanation is that psychologists who regularly engage in child-directed feedback are well-aware of its challenges and thus less likely to label past training as adequate or “sufficient.”

Limitations and Future Directions

As with similar Internet-based survey research, the response rate for the current study is not determinable. One method of recruitment was via relevant listservs, and with listservs it is impossible to know the number of people who opened the recruitment email, or even how many the message was successfully distributed to. Another method of recruitment involved posting a message on a private Facebook webpage group (i.e., APA Division 16). Again, it is impossible to know how many people viewed this post. Lastly, participants were recruited via emails that were obtained from the ABPP directory. After inclusion criteria was applied to the directory, emails were sent to approximately 350 individuals; however, I received numerous bounce-backs and out of office replies.

The chosen sampling method also limits the generalizability of the results. Though efforts were made to recruit respondents from several fields of study, including child and adolescent clinical psychology, independent practice, neuropsychology, and school psychology, a random sampling procedure was not enacted. Also, there is a possibility for sampling bias given that respondents were largely recruited from organizations that infer a degree of specialization and enthusiasm for their respective fields. For example, there are surely psychologists who perform child and adolescent assessments that are not board certified (i.e., ABPP) or belong to and regularly check psychology listservs. Future researchers may want to sample psychologists from an even broader field. A larger number of respondents could also provide more information about the factors that impact feedback provision.

Another limitation of this study pertains to self-administration. Surveys rely on the self-report of the respondents, which can pose validity problems (Mertens, 2009). Though the topic of the current questionnaire was relatively benign, it is possible that respondents

unknowingly provided dishonest answers, perhaps due to misunderstanding of questions or simply not knowing an answer. Of note, attempts were made to avoid such problems (e.g., use of open-ended questions and not including any forced-choice items). Relatedly, the current study may be limited by response bias. Some respondents may have answered certain questions with an awareness of the study's primary focus, and done so in a favorable or socially desirable way. For example, questions pertaining to the frequency of providing children with feedback and familiarity with collaborative and therapeutic assessment approaches may have been vulnerable to social desirability bias.

As mentioned above, some respondents used the open-ended items to make note of ambiguous language in the survey. In particular, several respondents asked about the reference to "collaborative and therapeutic assessment methods." This should have been clarified; for instance, by including a brief summary of the approaches or naming the C/TA pioneers.

The current sample also lacked ethnic and racial diversity, with those who self-identified as White/European American overrepresented. Females were also somewhat overrepresented in the current sample. This may reveal problems in sampling, or be reflective of the greater population of psychologists who engage in child and adolescent assessment.

The present survey instrument was designed for this study given the absence of an existing measure. The contents were guided by the research problem and existing scholarship on feedback practices, particularly from the collaborative and therapeutic assessment fields. Though piloted, it was still a novel measure and would clearly benefit from further refinement. For example, future research could improve upon the survey by reducing item ambiguity and the possibility of social desirability responding. It could also investigate more explicitly how psychologists make the decision about providing feedback to various parties (e.g., what

determines whether a child or adolescent can “comprehend” the results?). In addition, while results from the current study indicate a lack of consensus among psychologists about their “ethical responsibility” to provide feedback to minors, this topic could be further explored.

Though the present study gathered much data about the practices and perspectives of psychologists on assessment feedback, as it was designed to do, it tells us little about the experiences of child assesseees and their families. It also tells us little about what components of client feedback support clinical change and improvement. Both should be investigated in future studies.

Implications

As intended, the current study informs the field of psychological assessment, particularly in the domain of child-directed feedback. Study findings provide insights to practicing psychologists, trainees, educators, and supervisors, as well as potentially benefit future clients and their families. Several implications are discussed below.

First, a good portion of psychologists in the current study find the sharing of feedback to benefit younger assesseees in addition to their parents/caregivers. To discount feedback, including with child assesseees, may be to miss a vital opportunity for therapeutic benefit. Even Pope (1992), the former chair of the APA’s Ethics Committee, asserted that “feedback may be the most neglected aspect of assessment” (p. 268). Thus, this research should be of interest to all psychologists who conduct assessments with individuals under the age of 18, and help guide them in their decisions about sharing findings. It is my hope that with increased awareness of its perceived value, psychologists will change how they conceptualize feedback, and ultimately expand their use of child-directed feedback practices.

The clinical significance of sharing feedback, a relatively brief practice, should also

appeal to managed care organizations that aim to contain health care costs while improving quality. One respondent in the current study mentioned having success billing therapy units (i.e., 90834/90837) for comprehensive feedback sessions. Several C/TA clinicians have also reported adequate reimbursement by managed care for therapeutic assessments when emphasizing the interventional components (Butcher, 2006; Finn, 2007; Raja, 2013; Tarocchi et al., 2013). With child assesseees, the cost effectiveness of feedback—and subsequent change—may be even greater; it is also in line with managed care’s intended emphasis on early and preventive care. Moreover, quality, individualized assessment can likely reduce long-term costs by improving diagnostic accuracy and individualizing treatment recommendations (Cashel, 2002; Weiner, 2013).

This research also has potential to influence consumer satisfaction. Finn (2007), for example, found that many assessment clients were not satisfied with the feedback provided to them. A study by Bennett-Levy, Klein-Boonschate, Batchelor, McCarter, and Walton (1994) revealed that a majority of testing clients reported wanting more in-depth feedback. Also, a study conducted by Allen et al. (2003) found that clients who received personalized feedback (versus no feedback) reported being more satisfied with and having less negative feelings about the assessment experience. Increased awareness of this important practice may lead to more thorough feedback sessions that, consequently, better meet consumer’s expectations.

Present findings also indicate that psychologists are not receiving sufficient training in the area of assessment feedback while in graduate school. Graduate programs and their associated practicum/externship sites should place greater emphasis on the feedback process. For instance, this could include reviewing APA ethical standards and competency benchmarks as they relate to assessment, assigning relevant literature (e.g., Finn & Tonsager, 1997; Postal &

Armstrong, 2013; Tharinger, Finn, & Wilkinson et al., 2008), and engaging in modeling and role-play exercises. This may also require assessment instructors to become more familiar with the literature themselves. Many current survey respondents also discussed the need for more practical, real-world training experiences in feedback. This should ideally occur during practica and prior to internship. At the same time, results indicated that many respondents reported interest in receiving additional training in the delivery of feedback to children and adolescents. Thus, already practicing psychologists should seek continuing education or independent training experiences (e.g., therapeutic assessment seminars).

As broached above, this study revealed the critical role parents/caregivers play in the feedback process of their children. This was likely best illustrated by participant responses to the open-ended survey items; for example, that a main barrier to child-directed feedback is parent unwillingness for their child to hear findings. This finding implores evaluators to explore parents' concerns and make attempts to alleviate them as clinically indicated. This should ideally occur prior to the designated feedback session, given the aforementioned theme of scheduling barriers.

Psychological testing is psychology's distinctive contribution. It is imperative that psychologist assessors stay current on the relevant research and make decisions in the best interest of their clients. For years, the literature disregarded client-directed feedback, notably to children and adolescents. The present research adds to growing body of literature in support of this practice, while also affording several areas for further investigation.

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Table 1

Demographics of Respondents

Demographics	Frequency	%
Gender		
Female	104	76.5
Male	31	22.8
Other	1	0.74
Field of Degree		
Clinical Psychology	80	58.8
Neuropsychology	25	18.4
School Psychology	17	12.5
Counseling Psychology	7	5.2
Other	7	5.2
Graduation Year		
1970-1979	5	3.7
1980-1989	17	12.7
1990-1999	19	14.2
2000-2009	43	32.1
2010-2019	50	37.3
Racial/Ethnic Background		
White/European American	116	85.9
Other	5	3.7
Non-Hispanic Multi-Ethnic	5	3.7
African American/Black	4	3.0
Asian	3	2.2
Hispanic/Latino/a	2	1.5
Practice Setting		
Independent/Private Practice	65	46.8
Medical Center/Hospital	53	38.1
School System	8	5.8
Child/Adolescent Psychiatric Clinic	7	5.0
Other	4	2.9
Community Mental Health	2	1.4

Note. *N* ranges from 134 to 139 due to omitted responses.

Table 2

Purpose of Child/Adolescent Assessment

Purpose	Frequency	%
Answer referral question(s)	132	94.9
Diagnose/confirm diagnosis	129	92.8
Assist in educational services	116	83.5
Help assessee gain insight	73	52.5
Serve as a therapeutic intervention	43	30.9
Inform legal decisions	28	20.1
For research	21	15.1
Other	11	7.9

Notes. $N = 139$. Respondents were allowed to select all purposes for which they conduct assessments with children and adolescents.

Table 3

Parties that Regularly Receive Assessment Results

Receiving Party	Frequency	%
Parent/caregiver(s) of the child/adolescent assessed	136	97.8
Other treatment provider(s)	101	72.7
The child/adolescent assessed	98	70.5
School system/personnel	90	64.7
Legal system	31	22.3
Other	12	8.6
No one/Assessments are for own or research use	2	1.4

Notes. $N = 139$. Respondents were allowed to select all parties to which they regularly provide assessment results.

Table 4

Results of the Friedman Test for Differences Between Age Groups on Frequency of Feedback Provision

Age Group	Mean Rank	X^2	df	p
Children ages 8 and younger	1.43	304.302	3	< .001
Children ages 9-11	2.00			
Adolescents ages 12-14	2.99			
Adolescents ages 15-17	3.59			

Table 5

Frequency of Feedback Provision to Parents/Caregivers

Feedback Type	Response	Frequency	%
Verbal assessment feedback	Never	1	0.7
	Rarely	1	0.7
	Sometimes	1	0.7
	Usually	22	15.8
	Every Time	113	81.3
	Missing	1	0.7
Written summary/report	Never	1	0.7
	Rarely	3	2.2
	Sometimes	3	2.2
	Usually	12	8.6
	Every Time	120	86.3
	Missing	0	0.0

Notes. $N = 139$. Missing refers to omitted responses.

Table 6

Frequency of Feedback Provision to Children and Adolescents

Age Group	Response	Frequency	%
Children ages 8 and younger	Never	30	21.6
	Rarely	61	43.9
	Sometimes	27	19.4
	Usually	9	6.5
	Every Time	8	5.8
	Missing	4	2.9
Children ages 9-11	Never	12	8.6
	Rarely	39	28.1
	Sometimes	58	41.7
	Usually	17	12.2
	Every Time	9	6.5
	Missing	4	2.9
Adolescents ages 12-14	Never	3	2.2
	Rarely	12	8.6
	Sometimes	50	36
	Usually	50	36
	Every Time	22	15.8
	Missing	2	1.4
Adolescents ages 15-17	Never	2	1.4
	Rarely	3	2.2
	Sometimes	25	18
	Usually	72	51.8
	Every Time	36	25.9
	Missing	1	0.7

Notes. $N = 139$. Missing refers to omitted responses.

Table 7

Results of Spearman's Correlation Between Frequency of Feedback Provision and Years Since Graduation

Age Group	<i>N</i>	<i>r_s</i>	<i>p</i>
Children ages 8 and younger	130	-0.07	.44
Children (9-11)	130	-0.13	.13
Adolescents (12-14)	132	-0.12	.17
Adolescents (15-17)	133	-0.21*	.02
Parent/caregiver of minor assessed	133	-0.10	.25

Note. *Correlation is significant at the 0.05 level.

Table 8

Results of Spearman's Correlation Between Frequency of Feedback Provision and Perspective on Ethical Responsibility to Share Feedback

Age Group	<i>N</i>	<i>r_s</i>	<i>p</i>
Children ages 8 and younger	132	0.49*	< .001
Children (9-11)	132	0.44*	< .001
Adolescents (12-14)	134	0.44*	< .001
Adolescents (15-17)	135	0.43*	< .001

Note. *Correlation is significant at the 0.05 level.

Table 9

Results of Spearman's Correlation Between Frequency of Feedback Provision and Perspective on Feedback Being Beneficial

Age Group	<i>N</i>	<i>r_s</i>	<i>p</i>
Children ages 8 and younger	134	0.50*	< .001
Children (9-11)	134	0.47*	< .001
Adolescents (12-14)	136	0.29*	< .001
Adolescents (15-17)	137	0.34*	< .001

Note. *Correlation is significant at the 0.05 level.

Table 10

Results of Spearman's Correlation Between Frequency of Feedback Provision and Perspective on Feedback Causing Harm

Age Group	<i>N</i>	<i>r_s</i>	<i>p</i>
Children ages 8 and younger	133	-0.38*	< .001
Children (9-11)	133	-0.25*	< .001
Adolescents (12-14)	135	-0.20*	.02
Adolescents (15-17)	136	-0.14	.10

Note. *Correlation is significant at the 0.05 level.

Table 11

Reasons for Providing Feedback

Group	Response	Frequency	%
Children (ages \leq 11)	It can improve self-insight	105	75.5
	It can elicit positive change	106	76.3
	It is my ethical responsibility	20	14.4
	It is required practice at my work setting	5	3.6
	Other	17	12.2
Adolescents (ages 12-17)	It can improve self-insight	134	96.4
	It can elicit positive change	127	91.4
	It is my ethical responsibility	43	30.9
	It is required practice at my work setting	7	5.0
	Other	12	8.6
Parent/caregiver of minor	It can improve understanding	138	99.3
	It can elicit positive change	123	88.5
	It is my ethical responsibility	123	88.5
	It is required practice at my work setting	51	36.7
	Other	12	8.6

Notes. $N = 139$. Respondents were allowed to select all reasons that they provide feedback to clients of each group.

Table 12

Barriers to Providing Feedback

Group	Response	Frequency	%
Children (ages \leq 11)	Assessee unable to understand findings	110	79.1
	Unprepared to communicate feedback	12	8.6
	Challenges related to negative findings	36	25.9
	Feedback could cause harm	34	24.5
	Refused to participate	27	19.4
	Time constraints	26	18.7
	No financial reimbursement	3	2.2
	Other	38	27.3
Adolescents (ages 12-17)	Assessee unable to understand findings	83	59.7
	Unprepared to communicate feedback	8	5.8
	Challenges related to negative findings	20	14.4
	Feedback could cause harm	30	21.6
	Refused to participate	47	33.8
	Time constraints	27	19.4
	No financial reimbursement	3	2.2
	Other	41	29.5
Parent/caregiver of minor	Parent unable to understand findings	5	3.6
	Unprepared to communicate feedback	2	1.4
	Challenges related to negative findings	0	0
	Feedback could cause harm	0	0
	Refused to participate	13	9.4
	Time constraints	6	4.3
	No financial reimbursement	1	0.7
	Other	17	12.2

Notes. Respondents were allowed to select all reasons for why they do not provide feedback to clients of each group. *ns* are lower for the parent/caregiver group due to automatized skip patterns in the survey.

Table 13

Sufficiency of Past Training in Providing Feedback to Children/Adolescents and to Adults

Client group	Response	Frequency	%
Children/adolescents	Strongly disagree	17	12.2
	Somewhat disagree	25	18
	Neither agree nor disagree	8	5.8
	Somewhat agree	42	30.2
	Strongly agree	47	33.8
	Missing	0	0
Adults	Strongly disagree	10	7.2
	Somewhat disagree	17	12.2
	Neither agree nor disagree	14	10.1
	Somewhat agree	27	19.4
	Strongly agree	69	49.6
	Missing	2	1.4

Notes. $N = 139$. Missing refers to omitted responses.

Table 14

Results of Spearman's Correlation Between Frequency of Feedback Provision to Children and Adolescents and Sufficiency of Past Training

<i>Age Group</i>	<i>N</i>	<i>r_s</i>	<i>p</i>
Children ages 8 and younger	135	0.14	.11
Children (9-11)	135	0.14	.12
Adolescents (12-14)	137	0.13	.13
Adolescents (15-17)	138	0.16	.06

Note. *N* ranges from 135 to 138 due to omitted responses.

Table 15

Helpfulness of Various Training Experiences in Learning to Provide Feedback to Children and Adolescents

Training Experience	Response	Frequency	%
Doctoral coursework	Not at all helpful	34	24.5
	Slightly helpful	40	28.8
	Somewhat helpful	34	24.5
	Moderately helpful	16	11.5
	Extremely helpful	12	8.6
	Missing	3	2.2
Practicum/Externship	Not at all helpful	16	11.5
	Slightly helpful	22	15.8
	Somewhat helpful	25	18
	Moderately helpful	38	27.3
	Extremely helpful	37	26.6
	Missing	1	0.7
Pre-doctoral internship	Not at all helpful	11	7.9
	Slightly helpful	11	7.9
	Somewhat helpful	25	18
	Moderately helpful	41	29.5
	Extremely helpful	48	34.5
	Missing	3	2.2
Postgraduate training	Not at all helpful	9	6.5
	Slightly helpful	8	5.8
	Somewhat helpful	19	13.7
	Moderately helpful	38	27.3
	Extremely helpful	62	44.6
	Missing	3	2.2

Notes. $N = 139$. Missing refers to omitted responses.

Table 16

Level of Interest in Receiving Additional Training in Providing Feedback to Children and Adolescents

Response	Frequency	%
Not at all	30	21.6
Slightly	20	14.4
Somewhat	35	25.2
Moderately	41	29.5
Extremely	13	9.3

Note. $N = 139$

Appendix A

Survey of Assessment Feedback Practices

1. In your practice, do you conduct psychological assessments (e.g., intellectual/achievement testing, neuropsychological batteries, objective and/or projective/performance personality measures, symptom-based inventories) with **children** and/or **adolescents**?
 - a. Yes
 - b. No
2. In what setting do you primarily conduct psychological assessment with children and/or adolescents?
 - a. Child/Adolescent Psychiatric or Pediatric Clinic
 - b. Community Mental Health Center
 - c. Consortium
 - d. Independent/Private Practice
 - e. Medical Center or Hospital
 - f. School System
 - g. Other (please specify): _____
3. In general, for what purpose(s) do you conduct psychological assessment with children and/or adolescents? (select all that apply)
 - a. To diagnose/confirm diagnosis
 - b. To answer referral question(s)
 - c. To help the assessee gain insight
 - d. To serve as a therapeutic intervention
 - e. For research
 - f. To assist in school placement/educational services
 - g. To inform legal decisions (e.g., forensic and child custody evaluations)
 - h. Other (please specify): _____
4. When conducting psychological assessments with children and adolescents, with whom do you regularly share testing results? (select all that apply)
 - a. No one/Assessments are for own or research use
 - b. Parent/caregiver(s) of the child/adolescent assessed
 - c. The child/adolescent assessed
 - d. Other treatment provider(s)
 - e. School system/personnel

- f. Legal system
 - g. Other (please specify): _____
5. What modality (modalities) do you typically use to deliver assessment results? (select all that apply)
- a. Results are delivered verbally
 - b. A brief written summary
 - c. A formal written report
 - d. A personalized letter
 - e. A fable or story
 - f. Other (please specify): _____

6. How often do you provide a written summary/report to parents/caregivers of assessed children and adolescents?
- a. Never
 - b. Rarely
 - c. Sometimes
 - d. Usually
 - e. Every time

7. When working with children and adolescents, please indicate how often you provide verbal assessment feedback directly to the following:

	Never	Rarely	Sometimes	Usually	Every time
Parent/caregiver of minor assessed	<input type="checkbox"/>				
Children ages 8 and younger	<input type="checkbox"/>				
Children ages 9-11	<input type="checkbox"/>				
Adolescents ages 12-14	<input type="checkbox"/>				
Adolescents ages 15-17	<input type="checkbox"/>				

8. Please indicate your reason(s) for providing parents/caregivers with assessment feedback: (select all that apply)
- a. It can improve parent/caregiver understanding
 - b. It can elicit positive change
 - c. It is my ethical responsibility
 - d. It is required practice at my work setting
 - e. Other (please specify): _____

9. On the occasions when you do not provide feedback to parents/caregivers, please indicate your reason(s): (select all that apply)
- Parent/caregiver was unable to understand assessment findings
 - I felt unprepared to communicate feedback effectively
 - Specific challenges (e.g., anxiety, discomfort) related to providing negative assessment findings
 - I thought feedback could cause harm to the parent/caregiver
 - Parent/caregiver refused to participate
 - Time constraints
 - No financial reimbursement for feedback
 - Other (please specify): _____
10. Please indicate your reason(s) for providing adolescents (ages 12-17) with feedback: (select all that apply)
- It can improve self-insight
 - It can elicit positive change
 - It is my ethical responsibility
 - It is required practice at my work setting
 - Other (please specify): _____
11. On the occasions when you do not provide feedback to adolescents (ages 12-17), please indicate your reason(s) (select all that apply)
- Adolescent was unable to understand assessment findings
 - I felt unprepared to communicate feedback effectively
 - Specific challenges (e.g., anxiety, discomfort) related to providing negative findings
 - I thought feedback could cause harm to the adolescent
 - Adolescent refused to participate
 - Time constraints
 - No financial reimbursement for feedback
 - Other (please specify): _____
12. Please indicate your reason(s) for providing children (ages ≤ 11) with feedback? (select all that apply)
- It can improve self-insight
 - It can elicit positive change
 - It is my ethical responsibility
 - It is required practice at my work setting

e. Other (please specify): _____

13. On the occasions when you do not provide feedback to children (ages ≤ 11), please indicate your reason(s) (select all that apply)

- a. Child was unable to understand assessment findings
- b. I felt unprepared to communicate feedback effectively
- c. Specific challenges (e.g., anxiety, discomfort) related to providing *negative* findings
- d. I thought feedback could cause harm to the child
- e. Child refused to participate
- f. Time constraints
- g. No financial reimbursement for feedback
- h. Other (please specify): _____

14. What do you think would be helpful in increasing your motivation and/or ability to provide assessment feedback?

15. Please indicate how much you agree with the following statement: I received sufficient supervised training in the delivery of assessment feedback to:

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Children and adolescents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. How helpful were the following in your learning to provide feedback specifically to children and

	Not at all helpful	Slightly helpful	Somewhat helpful	Moderately helpful	Extremely helpful
Doctoral coursework	<input type="checkbox"/>				
Practica/Externship	<input type="checkbox"/>				
Pre-doctoral internship	<input type="checkbox"/>				
Postgraduate training	<input type="checkbox"/>				

adolescents?

17. How interested are you in receiving additional training in the delivery of assessment feedback to children and adolescents?

- a. Not at all
- b. Slightly
- c. Somewhat
- d. Moderately
- e. Extremely

18. Please indicate how much you agree with the following statement: Face-to-face assessment feedback is appropriate for:

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Parents/caregivers of child assessees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adolescents (ages 12-17)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children (ages ≤11)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. Please indicate how much you agree with the following statement: It is my ethical responsibility to make feedback available to:

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Parents/caregivers of child assessees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adolescents (ages 12-17)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children (ages ≤11)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. Please indicate how much you agree with the following statement: Providing assessment feedback can be beneficial for:

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Parents/caregivers of child assessees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adolescents (ages 12-17)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children (ages ≤11)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. Please indicate how much you agree with the following statement: Providing assessment feedback can cause harm to:

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Parents/caregivers of child assessees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adolescents (ages 12-17)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children (ages ≤11)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. Please indicate how familiar you are with collaborative and therapeutic assessment practices:

- a. Not at all
- b. Slightly
- c. Somewhat
- d. Moderately
- e. Extremely

23. How often do you utilize collaborative and therapeutic assessment practices in your assessments with children and adolescents?

- a. Not at all
- b. A little
- c. Somewhat
- d. Quite a lot
- e. Every time

24. How often do you elicit client participation during feedback session(s)?

- a. Not at all

- b. A little
 - c. Somewhat
 - d. Quite a lot
 - e. Every time
25. Please provide your thoughts on how the purpose of the assessment (e.g., educational, neuropsychological, personality) and/or the referral question may affect the feedback process.
-
-

26. Please select your highest degree attained:

- a. Ph.D.
 - b. Psy.D.
 - c. Ed.D.
 - d. Other (please specify): _____
27. In what year did you attain this degree? _____

28. In what field is your degree?

- a. Clinical Psychology
- b. Counseling Psychology
- c. School Psychology
- d. Neuropsychology
- e. Other (please specify): _____

29. How would you describe yourself?

- a. Female
- b. Male
- c. Transgender
- d. Not listed: _____

30. What is your racial/ethnic background?

- a. African American/Black
- b. American Indian or Alaska Native
- c. Asian
- d. Hispanic/Latino/a
- e. Native Hawaiian/Other Pacific Islander
- f. White/European American
- g. Non-Hispanic Multi-Ethnic
- h. Other (please specify): _____

31. If there is anything else you would like to share, we greatly appreciate your comments and experiences regarding child-directed feedback provision.

Appendix B
Survey Recruitment Letter

Dear Colleague,

The practice of psychological assessment has long helped to distinguish psychologists' professional identity, and it continues to be a core component of clinical training and activity. While numerous studies have explored the usefulness of assessment, little has been written on the practice of sharing test feedback with clients. This is especially true for clients under the age of 18. With your help, the current study will expand past research conducted in this area.

To advance the understanding of assessment feedback activities, I am requesting your participation in an online survey developed for my dissertation research. You will be asked to respond to questions about your professional practices related to assessment, as well as your attitudes toward these practices. To this end, I am seeking participation from psychologists who have experience engaging in some form of assessment with children and/or adolescents. This anonymous, online survey will take approximately 10 minutes to complete. Upon completion of the survey, you will have the opportunity to enter a random drawing to win a \$100 gift card.

To consent to the research and complete the online survey, please click the following hyperlink:
<https://survey.az1.qualtrics.com/████████████████████>

Your participation is greatly appreciated, and thank you in advance for your consideration.

Sincerely,

Caitlin Dolan, M.S.
Doctoral Candidate in Clinical Psychology
Antioch University New England
████████████████████

Appendix C
Survey Recruitment Letter: Listserv

Dear Colleagues,

I am requesting your participation in an online survey that aims to explore the practice of sharing assessment feedback with child/adolescent clients. You will be asked to respond to questions about your professional practices related to assessment, as well as your attitudes toward these practices. To this end, I am seeking participation from **psychologists who have experience engaging in some form of assessment with children and/or adolescents**. This anonymous, online survey will take approximately 10 minutes to complete. Upon completion of the survey, you will have the opportunity to enter a random drawing to win a \$100 gift card.

To complete the online survey, please click the following hyperlink:
[https://survey.az1.qualtrics.com/\[REDACTED\]](https://survey.az1.qualtrics.com/[REDACTED]), or contact me directly at this email.

Your participation is greatly appreciated.

Sincerely,

Caitlin Dolan, M.S.
Doctoral Candidate in Clinical Psychology
Antioch University New England
[REDACTED]

Appendix D
Informed Consent

Dear Practitioner:

You are invited to participate in a study of psychological assessment practices. This research is being conducted as part of my dissertation and doctoral degree at Antioch University New England, and under the advisement of the faculty dissertation chair Theodore Ellenhorn, PhD. Please read this document in entirety prior to consenting to participate in this study.

The purpose of this study is to better understand psychologists' current practices and perspectives regarding the provision of psychological assessment feedback to children and adolescents. Your participation in the study is anonymous, and requires completion of an online survey. If you consent to this study, please answer all questions honestly. You do not have to answer any question that you do not want to. The survey should take approximately 10 minutes to complete. When you have completed the survey, a cookie will prevent multiple submissions.

Participation in this survey is voluntary. Your responses will be anonymous, and you will not be asked to provide any identifying information. The information that you provide will only be used for research purposes. Also, the online survey does not track IP or email addresses. There are no known risks associated with participation in this study. Although there are no known personal benefits to participation, you will be contributing to research that has implications for the practice of psychological assessment. Also, for your time, you will have the opportunity to enter a random drawing to win a \$100 Amazon gift card. If you choose to participate in the drawing, the contact information you provide for that will not be linked to your survey, and will also be kept strictly confidential. After the drawing is complete and the gift card sent, your contact information will be destroyed.

This study received approval from Antioch University New England's IRB. If you have any questions about your rights as a research participant, you may contact Dr. Kevin Lyness, Chair of the Antioch University New England's IRB, at [REDACTED], or Dr. Shawn Fitzgerald, Provost, at [REDACTED].

If you have any questions about this survey or would like more information, you are encouraged to contact the researcher of this study at [REDACTED].

Your participation is greatly appreciated.

Sincerely,

Caitlin Dolan, M.S.
Doctoral Candidate in Clinical Psychology
Antioch University New England¹

¹ The following appeared at the bottom of the Electronic Informed Consent and included a dichotomous response format: "By responding to the question below, it means you have read the information contained in the above Informed Consent, and agree to participate in this research study: Yes, I have read the informed consent. No, I do not agree to participate in the study."